# LAW AND CONTEMPORARY PROBLEMS

## MEDICAL CARE

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### MEDICAL CARE





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# LAW AND CONTEMPORARY PROBLEMS

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## FOREWORD

Developments within a surprisingly few years have translated the problem of extending medical care from the domain of agitation to that of action. This action is manifesting itself in a variety of forms, but two major trends may be observed. The first is the development of corporations and associations, sponsored either by medical associations or by consumer groups and governmental agencies, which have been organized to provide hospital service and, more lately, medical care on a prepayment basis. The second is the proposed extension of the Social Security Act's machinery for grants-in-aid so as to make additional federal funds available to subsidize state health plans.

One of the consequences of the rapidity with which these trends have developed is that the literature of the medical care problem has not kept abreast of them. Attention has been concentrated for the most part on factual questions of need and cost and on broad issues of social policy. Now that corporations are being organized, state enabling acts passed, litigation arising, and major federal legislation pending, it becomes important to consider the legal and administrative problems which are being encountered. It is to that objective that this symposium is devoted. Its purpose is not to demonstrate that one or another form of organization or procedure is the best means of meeting current needs. It does seek to indicate something of the anatomy, physiology, and pathology of the legal institutions which are being developed or may be called into being.

This symposium, furthermore, is concerned only with those measures which may be regarded as direct attacks on the problem of making good medical care more generally available. From this no inference should be drawn that the direct attack alone is of consequence. Certainly there is need for extension and improvement in public health education, in scientific research, and in the training of the professions—especially with respect to postgraduate instruction. Moreover, to echo a complaint directed by spokesmen for the American Medical Association against the National Health Bill, the problem of inadequate medical care is related to the problem of poverty and measures which would improve the standard of living of the low income groups in the population would likewise raise their standards of health and medical care. But, as treatment of the pellagra victim is not deferred by the physician until the agricultural economy of the South and the dietary deficiencies consequent thereon

are changed, so the existence of long-term, and perhaps more basic, approaches to the problem of medical care does not demonstrate the unwisdom or futility of considering more immediate and direct attacks on the problem. Obviously any adequate discussion of long-term measures would require at least another volume and carry this symposium into fields far removed from the area of legal action.

The organization of this symposium reflects the two major trends in current developments which were remarked above. After an introductory article, the succeeding eight articles discuss problems related to prepayment plans, chiefly under private auspices, for providing hospital and medical services. The remaining articles in the symposium are focussed upon the National Health Bill, introduced by Senator Wagner in the last session of Congress and popularly known as the Wagner Bill. To aid the reader not familiar with this measure, a brief outline of its provisions will be given here.

The National Health Bill takes the form of an amendment to the Social Security Act, amending certain existing titles and adding others. All the amended and new titles authorize the federal government to make grants in aid of state plans established for specified types of medical care and medical or cash benefits to the sick. The formulae whereby these grants are to be made vary from title to title and depart in one important respect from the familiar grant-in-aid practice. They are examined and appraised in the concluding article of the symposium.[1]

Section 2 of the National Health Bill amends Title V of the Social Security Act, "Grants to States for Maternal and Child Welfare," in particular, Part 1, "Maternal and Child Health Services," Part 2, "Medical Services for Children and Services for Crippled and Other Physically Handicapped Children," and Part 4, "Administration." Section 3 amends Title VI, "Public-Health Work and Investigations." Section 4 adds new Titles XII, XIII and XIV to the Social Security Act. Title XII, "Grants to States for Hospitals and Health Centers," authorizes the appropriation of federal funds over a period of three years in aid of state plans for the construction and operation of needed hospitals, including "health, diagnostic, and treatment centers, institutions, and related facilities." Title XIII authorizes grants in aid of state plans "to extend and improve medical care." Under this title, state plans might either provide additional public medical services or create systems of compulsory health insurance. Title XIV, "Grants to States for Temporary Disability Compensation," authorizes federal grants in aid of state plans to provide cash benefits to persons suffering physical disabilities not arising out of their employment. The plans contemplated by this title would supplement both the workmen's compensation and the unemployment compensation laws.

D. F. C.

[1] This article provides a convenient chart listing each title, its purpose, the amount of the authorized federal grant, and the basis for computing the matching grants required of the states.

# AN INTRODUCTION TO NATIONAL PROBLEMS IN MEDICAL CARE

I. S. Falk*

## I

It is so much the fashion to write of mankind, nations, democracies or social institutions "at the crossroads" that we tend to become indifferent to the phrase. Yet it is no exaggeration to say that medicine is at a crossroads. Changes in its technology and in its social environment press it irresistibly onward. The traffic at the crossroads is heavy and fast. Medicine cannot stand still. There are many roads ahead. Which shall it follow?

Modern medicine[1] is not an esoteric art; its foundation is the broad base of modern science. A great profession, endowed with centuries of tradition, is the custodian of a growing body of knowledge. The practice of medicine is now not only an art but also a social institution; as such it is subject to all the influences which affect such institutions, and it is responsive to the changing environment in which it must function. Medicine is not today what it was yesterday nor what it will be tomorrow. The spread of education and the augmented capacities for the conservation of health create enlarged demands for service, so that medicine is increasingly exposed to the pressure of social change.

The role of social factors in affecting health and well-being began to be recognized about two centuries ago when Ramazzini studied occupational diseases. However, the systematic study of social factors in medicine took form only about two generations ago as a specialty of medicine, known as "social medicine."[2] This development came largely in response to the hygienist's need to understand the influences of conditions of living upon the laborer's health, and the physician's need to answer prob-

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[1] The word "medicine" is used, throughout this article, in its broad sense, to embrace the science and the art of prevention, cure or alleviation of disease. It includes private and public services furnished by physicians, dentists, nurses, hospitals, clinics, public health agencies, etc. At many points, it also includes the functional arrangements through which the technology of medicine operates.

[2] See, *e. g.*, Sand, Health and Human Progress, An Essay in Sociological Medicine (1935).

lems of diagnosis and therapy affected by occupation, diet, housing, mental strain and similar factors made important by industrial change and altered habits of living. This new study met relatively little response as a formal discipline in medical education or in medical practice; its techniques were diffuse, so that it lacked appeal to physicians accustomed to deal with the problems of individual patients rather than of statistical groups. It remained a specialty of medicine, instead of becoming a pattern for medical statesmanship. Its objectives have recently been served in some measure by the social teachings of hygiene and public health and by special courses given in a few schools interested in social factors.

The needs out of which social medicine first developed continued to exist and to provide a stimulus for developments in the social sciences. As a result, though social medicine is today almost unknown in medicine, medical sociology is taking definitive form and medical economics is extensively cultivated. Formerly, an inventory of medical facilities dealt with medical practitioners, hospitals, clinics and patients; now such an inventory must include the medical social-work professions, and it is a commonplace to speak of "producers," "consumers," and the problems of "distribution" peculiar to the health services.

There is a current phrase that "change comes to the doctor"; but this expresses only a part truth if it fails to imply that change comes to society and therefore to medicine. Societal adjustments have forceful impacts on the institution which we summarize in the term medicine, on its place in the society which it serves, and on the arrangements through which it operates. Some practitioners, absorbed in their daily tasks and unaware of changing social attitudes among many of their patients, are accustomed to think that they are privileged not only to pursue their profession but also to determine its place and its functional organization in society. It is difficult for them to appreciate that "He that reckons without his host must reckon again."

The plans for the future which now engage our attention must take account of the technology of medicine and the change it is likely to undergo. They must also take account of the social needs and the economic capacities of the people whom this technology is intended to serve.

## II

The socio-economic proposals which confront medicine today can be fully understood only when viewed in their historical perspective.[3] Such an historical review would go far afield from the present task, but the high points of a few recent developments must be mentioned here.

About twenty years ago, there was an active movement in the United States for the amelioration of economic risks created by sickness. This movement expressed itself in an educational and legislative campaign for social insurance, led by the

[3] SIGERIST, AMERICAN MEDICINE (1934) (translated by Hildegarde Nagel); THE MEDICAL PROFESSION AND THE PUBLIC, AM. ACAD. OF POL. AND SOC. SCIENCE (1934); CABOT, THE DOCTOR'S BILL (1935); BROWN, PHYSICIANS AND MEDICAL CARE (1937); RIESMAN, MEDICINE IN MODERN SOCIETY (1938); Shryock, *Freedom and Interference in Medicine* (Nov. 1938) 200 ANNALS 32.

American Association for Labor Legislation during the years 1915-1920.[4] A demand for enactment of health insurance mirrored and focused the problems of health needs. But public indifference, conflicts with vested interests, opposition of labor and of medical groups, political ineptitudes, and the cross currents of the World War defeated the movement on all fronts.

About ten years ago, the issues again became prominent. Medicine had become more complex. Public education had brought an increasing realization of the beneficent values of modern medical service. Despite the glow of prosperity enjoyed in the nineteen twenties, it was already widely recognized that large proportions of the population cannot purchase the medical care they need. This was a period of great faith in the impelling strength of factual surveys, and a careful study of medicine, its costs, its place in society and the adequacy of its organization was undertaken. The Committee on the Costs of Medical Care—a non-official body including representatives from many interested fields—devoted five years to the task, between 1927 and 1932.[5] A large body of information was accumulated. But when the time came to draw conclusions and to look to the future, the Committee divided sharply. There was liberal indulgence in the search for compromises among conflicting interests, but even this did not close the breach between progressive and conservative groups. The conservatism of medical leadership, then and subsequently, frustrated earnest efforts to find rational solutions through voluntary efforts.

About five years ago, the depression crisis brought proposals for social and economic security within the ambit of national legislation. The health program, which at first was of a piece with the programs for old age, public assistance and employment security, crashed on the rocks of organized professional opposition.[6] But a strong tide of public opinion was already running in, and compromises had to be accepted. The less controversial public health and maternal and child health programs received professional as well as lay endorsement, and were enacted by Congress in the Social Security Act of 1935.[7] Thus, while "face" was saved on all sides through these limited enactments, the proposals for health and disability insurance were left to founder.

Last year, the increasing public interest in health needs reached a new height. The relative indifference or inactivity of many groups, and the national scope of the problems, compelled the federal government to take the initiative in formulating a national health program. A long-range plan was developed and sponsored by the President's Interdepartmental Committee to Coordinate Health and Welfare Activities, and it was presented to the public at the suggestion of the President. It received

[4] Andrews (editor), *Health Insurance, A Positive Statement in Answer to Opponents* (1917) 7 AM. LABOR LEGIS. REV. No. 4; Chamberlain, *Constitutionality of Health Insurance and the Relation of the Social Worker Thereto*, PROCEEDINGS OF NAT. CONF. OF SOCIAL WORK (1917); WILLIAMS, THE PURCHASE OF MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT (1932).

[5] COMM. ON COSTS OF MEDICAL CARE, FIVE-YEAR PROGRAM, Pub. No. 1 (1928); FALK, ROREM AND RING, THE COSTS OF MEDICAL CARE, Pub. No. 27 (1933); MEDICAL CARE FOR THE AMERICAN PEOPLE: FINAL REPORT, COMM. ON COSTS OF MEDICAL CARE, Pub. No. 28 (1932).

[6] COMM. ON ECONOMIC SECURITY, REPORT TO THE PRESIDENT (1935).

[7] 49 STAT. 620 (1935), Titles V and VI.

substantial endorsement from representatives of major public groups at the National Health Conference of July 1938, and was transmitted to Congress by the President with a recommendation for careful study.[8] The bill introduced by Senator Wagner to implement this program, the public hearings by a sub-committee of the Senate Committee on Education and Labor, and the preliminary report of August 4, 1939, to the Senate indicate that the time for action has arrived.[9]

## III

It is important, at this time when specific legislative proposals are receiving serious consideration, that efforts should be made to cultivate a clear understanding of the social objectives and the underlying problems in a health program. Social concern with health service and medical care rests not only on humane but also on economic and political grounds. National vigor, social security, and political stability are intimately related to the physical and mental health of the individual. Society has a large stake in measures designed to reduce the incidence of illness or disability and to minimize their sequelae, a stake which is most plainly evident in the costs of dependency caused by illness, disablement or premature death.

Social and economic health measures are directed primarily to the effective organization of health facilities and to the adequate provision of health services. They are only secondarily concerned with the technology of medicine. The content of medicine is the physician's domain. But the circumstances under which he practices and his economic relation to society or to the individual patient are problems of organization, problems in the public domain in which the physician is only one among many who are vitally interested.

When the technology of medicine grew beyond the competence of any individual, specialization became essential. The number and variety of practitioners increased and their coordination became complex. Competition among and within the medical services became acute, and medical costs came into sharp competition with other demands upon the purchasing powers of the public. Through circumstances which no one planned and none foresaw, a profession found itself in a business world. Medicine has been trying to adapt itself to the world about it. The old order of competitive private practice strains itself to conform to social patterns which, in many ways, interfere with the social objectives and the ethical code of an honored profession. The medicine of today cannot afford to drift complacently or without direction into the medicine of tomorrow, unless society is prepared to see the virtues of a profession increasingly supplanted by the dynamics of business.

Social concern is founded on the doctrine that health services are essential and that the individual must be served regardless of his place in society, his individual

[8] Proceedings of the Nat. Health Conf., July 18-20, 1938; Message from the President of the United States Transmitting the Report and Recommendations on National Health Prepared by the Interdepartmental Committee to Coordinate Health and Welfare Activities, H. R. Doc. No. 120, 76th Cong., 1st Sess. (1939).

[9] National Health Bill, S. 1620, 76th Cong., 1st Sess., introduced Feb. 28, 1939; Sen. Comm. on Education and Labor, Preliminary Report on S. 1620 ("Establishing a National Health Program"), SEN. REP. No. 1139, 76th Cong., 1st Sess. (1939).

capacity to pay for services, or the magnitude of his needs. As a corollary, the practitioner and the institution which is to serve him must be supported, and there is, therefore, inevitably a financial relationship in which society, as well as physician and patient, is concerned. The economic problems which arise cannot be defined solely in terms of consumer needs or demands, production costs, and price policies. Other elements complicate any purely economic approach to the economic problems of medicine. There are ideals and humane considerations and elements of social prestige to be taken into account; and many attributes of a professional service are to be distinguished from the characteristics of a trade relation.

Medicine and the society which it serves must preserve a careful balance between professional controls in the provision of medical care and economic interests in the method of paying for it. Neither the one nor the other may be permitted to dominate.

Long ago the professional code dictated that the patient shall seek out the physician. The social doctrine now dictates that the patient's need shall be met. These are not incompatible, but their simultaneous application is not always practical without adjustments in the functional organization of medicine. The professional code holds fast to the principle of free choice of physician by the patient, not merely because it is an ancient maxim but because it is a safeguard of the patient's confidence and trust in his physician. Yet the principle comes into conflict with another maxim, long known to every student of social philosophy, calling for restriction of personal choice when "the consumer is not a proper judge of the quality of the ware."[10] Every proposal for new arrangements under which medicine shall serve the public need must take into account that in medicine, more than in almost any other field, the patient is deficient in knowledge and competence to judge his need, his purchase, or the fair price. Moreover, it is only confusing to focus on the principle of free choice while being myopic to the fact that, in many circumstances, the principle is already little practiced or observed. This is especially true in clinic and in subsidized hospital services, in communities where professional personnel is limited in number or variety, and in the diverse circumstances where the charges for service and the lack of public information limit free choice.

Nor is the physician—the hypothetical seller of a service in a free market—altogether analogous to the producer in our industrial exchange. He is probably closer to the public utility in which society, by reason of an imminent interest, vests a monopoly subject to limitations and restraints. Society determines who may hold himself out as a physician and, in return for his exclusive licensure, exacts from him the price of his professional code. It gives him special privileges in the services he may furnish and sell; but his code requires that he shall serve all who seek him out, without regard for their ability to pay. Social judgments and judicial pronouncements generally agree that he is entitled to a fee according to the patient's ability to pay—little or nothing from the poor, and in proportion to their means from the rich.

The sliding fee scale once served as a useful instrument whereby the physician

[10] Hamilton, Personal Statement in MEDICAL CARE FOR THE AMERICAN PEOPLE: FINAL REPORT, COMM. ON COSTS OF MEDICAL CARE, Pub. No. 28 (1932) p. 193.

adjusted his charge to the means of his patients and, in the net, earned his competence. In the complex urban and industrial world of today the practice cannot be so simple. The physician who serves the poor may be one who also serves the rich, or he may not. The burdens of free care are frequently too heavy for many practitioners. The public interest and, in turn, the public purse already intervene to meet the cost of services which might once have been the gratuity of the physician. Though public medical expenditures are already large, they are grossly inadequate and the public purse must increasingly intervene. But, obviously, when society provides financial support for services furnished to the poor, and relieves the physician of some of the burdens of free care, it deprives him, in equal measure, of his economic defense for the practice of adjusting upwards his charges to the well-to-do. Also, it transfers to a public officer the responsibility, formerly exercised by the physician, of determining that a patient is destitute and entitled to service without a direct charge.

A society which accepts broad responsibility for dependency and destitution must also make adequate provision for health services. Here financial arguments reinforce humane considerations. Society cannot afford to have prevention neglected or sickness unattended; it cannot afford to support the needy halt, blind, widowed, and orphaned whose dependency can be prevented through services that are available and relatively inexpensive. Inadequacies in the receipt of health service are luxuries which we cannot afford.

## IV

Proposals to extend and improve health services must be tested by the characteristics of existing deficiencies. The remedy must fit the need. A large volume of illness and disability occurs, year after year, from causes we know how to control; preventive services should be strengthened and expanded. An enormous volume of illness and disability is unattended, or is attended inadequately or too late in the course of the disease; remedial services should be made more generally available. Large numbers of people are without the means necessary, under prevailing arrangements, for the purchase of the services they need; they should be assisted to obtain these services within their means and under conditions which preserve dignity and self-respect. There are millions of people living in communities which are deficient in personnel and facilities essential for the furnishing of modern service; these deficiencies should be made good. There are millions who are inadequately educated in hygiene and the opportunities offered by modern medicine; health education should be expanded to equip them with the knowledge and understanding essential for the effective utilization of the health services. In each of these illustrations, and in many more of equal importance that could be cited, the need is rooted in social and economic problems and the remedy involves socio-economic adjustments.

An analysis of the underlying problems[11] is, in a sense, comparatively simple be-

[11] FALK, ROREM AND RING, THE COSTS OF MEDICAL CARE, Pub. No. 27 (1933); FALK, SECURITY AGAINST SICKNESS: A STUDY OF HEALTH INSURANCE (1936); CABOT, THE DOCTOR'S BILL (1935); MILLIS, SICKNESS AND INSURANCE (1937); REED, HEALTH INSURANCE (1937); AMA BUREAU OF MED. ECON., FACTUAL DATA ON MEDICAL ECONOMICS (1939); Perrott, Tibbits, and Britten, *The National Health Survey:*

cause there is one fundamental and causal problem to which most others are secondary or related. This primary problem arises from a basic characteristic of the incidence of illness and the variations in services and costs that are involved. Though the amount of illness which will occur in a population of any considerable size can be forecast with substantial accuracy, the individual cannot foresee the experience which he himself is likely to face. Illness strikes the individual in an unpredictable and uncertain manner. One person may go through a year of life or even many years with little or no illness of serious duration or severity; another may be stricken frequently and catastrophically.

The costs of illness or medical need are highly variable in their impacts upon family budgets and security. Small costs for medical care may be absorbed in a family budget which is above the bare subsistence level; but the occurrence of a "high cost" illness, even when moderate fees are charged for each unit of service, may be a financial catastrophe for a family of small, modest, or even substantial means.

Illness and disability are not considerate of the family exchequer, and large costs may fall upon small purses. The plain fact, well attested by numerous studies, is that families cannot, even if they would, budget against expenditures which come unexpectedly and which fluctuate within such broad ranges that they may exceed even annual income, and at the same time destroy earning power.[12]

Nor do the statistics of actual family expenditures tell the whole story. Knowing in advance that they cannot pay large medical bills, many families ask for "free" care, and many more go without medical attention which they know they need. Nor can anyone be unaware of the distress in those families which incur large bills and undertake to pay them. In one case or another, the savings of a lifetime may be wiped out, the hopes and dreams for a home or farm thwarted, educational opportunities sacrificed, the family deprived of the amenities of life. The burdens are equally great whether the result is unmet need or financial strain.

The main problem is concealed when the costs of sickness are examined in terms of average incidence or average charges. Proof that families could meet the average costs would have significance only if families were permitted or enabled to meet their obligations by paying the average costs. This is precisely the reason why many investigations have led to the conclusion that medical costs can be met by people, in

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*Scope and Method of the Nation-Wide Canvass of Sickness in Relation to Its Social and Economic Setting*, PUBLIC HEALTH REPORTS (Sept. 1939); Perrott, *The State of the Nation's Health* (Nov. 1936) 188 ANNALS 131; Perrott and Holland, *Health as an Element in Social Security* (March, 1939) 202 ANNALS 116.

[12] FALK, KLEM, AND SINAI, THE INCIDENCE OF ILLNESS AND THE RECEIPT AND COSTS OF MEDICAL CARE AMONG REPRESENTATIVE FAMILY GROUPS, Pub. No. 26 (1933); KLEM, MEDICAL CARE AND COSTS IN CALIFORNIA FAMILIES IN RELATION TO ECONOMIC STATUS (1935); DODD AND PENROSE, ECONOMIC ASPECTS OF MEDICAL SERVICES: WITH SPECIAL REFERENCE TO CONDITIONS IN CALIFORNIA (1939); Wilson and Metzler, *Sickness and Medical Care in an Ozark Area in Arkansas*, UNIV. OF ARK. BULL. No. 353 (1938); Krumlein, *The Rural Health Situation in South Dakota*, SOUTH DAKOTA STATE COLL. OF AGR. AND MECH. ARTS, BULL. No. 258 (1931); Wheeler, *Impairments in a Rural Population*, THE MILBANK MEMORIAL FUND QUARTERLY (July and Oct., 1937, Jan. and April, 1938); Klem, *Family Outlay for Hospital Care* (Feb. 1939) 52 MODERN HOSPITAL 45; Klem, *Family Expenditures for Medical and Dental Care* (1939) 26 JOURNAL OF THE AM. DENTAL ASS'N 828; Klem, *Who Purchase Private Duty Nursing Services?* (1939) 39 AM. JOURNAL OF NURSING 1069.

their respective stations in life and within their individual budgets, only if these costs are distributed among groups of people and over periods of time. This is equivalent to saying that the burdens of medical costs could be mitigated if the principle of insurance were applied.

Instalment payment should not be confused with insurance. Instalment payment distributes costs over time, but it does not distribute the primary risk among groups of people. Instalment payment of medical costs does not insure an individual or family against a future risk of medical bills; it only mortgages future earnings to pay for a catastrophe which has already occurred.

It is recognized, of course, that neither insurance nor any other budgeting device will solve the problem of those who have no means. For them, medical services—like food, clothing and shelter—must be provided, presumably at public expense.

Variations and uncertainties in sickness costs have their counterpart in variations and uncertainties in professional and institutional incomes. Sharp curtailment of income during the depression led many physicians to look with favor on the stabilized income of salaried practice and of service for insurance groups, and to demand tax support for services to the indigent—even though such tax funds were formerly viewed with grave suspicion as an entering wedge for state medicine.

The burden of costs for the "consumer" and the hazards of income for the "producer" are inextricably enmeshed with the economic resources of the community. Inadequacies in the incomes of individuals, groups and communities are reflected in variation in the ability to support medical practitioners and institutions. Usually those who are least able to meet medical costs are not only least able to support medical facilities but are also members of groups and communities which are least equipped with such facilities. This is all the more serious because, in general, those in the poorest economic circumstances have the highest sickness and disability rates, need the largest volumes of service and the most extensive personnel and facilities.

Intimately related to the economic problems of medical care are the corresponding problems concerned with disablement and disability wage-loss. The underlying problem here is quite like that which is created by the variations and uncertainties of individual medical costs. The average amount of disability which may occur among gainfully employed persons and the average loss of earnings would raise no grave issues if each had to bear only the average amount. But, in general, the individual worker can no more know in advance whether he will suffer little or much disability, or will become permanently disabled, than he can foretell how much sickness will befall him or his family or what the costs will be. Disablement of the mother and housewife may be tragic for the family; but disablement of the breadwinner brings catastrophe.

Among those who cannot accumulate substantial financial reserves—and this includes an overwhelming majority of the population—the fear of disability hangs like a sword of Damocles over the financial independence and the security of the family. It is therefore not surprising that nearly every large system of health insur-

ance furnishes both sickness services and wage-loss benefits, and that all but two of the large nations which have developed old age insurance (Spain and the United States) have provided protection against permanent retirement due to invalidity. Several countries have both sickness and invalidity insurance, or the latter only, though they do not have old age insurance. The assurance of health security involves not only prevention of disease but also protection against both the costs and the losses which illness brings in its wake.

## V

A health program for our country starts with a vast equipment: more than a million professional practitioners of all kinds (physicians, dentists, nurses, and technicians) and lay and semi-technical employees; approximately six thousand hospitals and special institutions, with more than a million beds; unexcelled schools for professional education and training; thousands or tens of thousands of clinics, health centers and institutions for public education and guidance; a network of health and welfare agencies at all levels of government—federal, state, and local; voluntary agencies which reach into almost every community, including national, regional and local organizations of civic, fraternal, religious, charitable and other associations familiar with health needs and devoted to the provision of health services. This vast armamentarium is available; its personnel is ready and eager for more extensive and more effective organization of public service. But neither such readiness nor such eagerness is sufficient to resolve practical difficulties or to avoid conflicts in aims and activities.

A new health program for the nation must strengthen and expand the preventive services; on this there is general agreement, but there are differences of opinion as to the extent to which these services should be performed as a public or as a private enterprise.

Special provisions must be made to safeguard maternity, infancy and childhood; on this there is little difference of opinion, but there are complex problems of relationship with the general health services and with private practices.

Inadequacies in hospital, clinic, health center and related facilities must be met; on this there is strong public support, but it divides into factions on secondary questions concerning the sources of funds, the location of new institutions, and the protection of existing facilities against competition from new ones.

Medical care must be furnished to the needy poor; on this public opinion reinforces professional demand, but there are deep cleavages as to the administrative mechanisms to be used, the basis of payments to practitioners, the allocation of responsibilities among official and non-official agencies, and the relative financial responsibilities of local, state and national governments.

Medical care must be made available to people of small means under arrangements which avoid the burdens of variable and uncertain costs, safeguard quality, and assure support to professional personnel and facilities; on this there is wide

agreement in principle, but there are also sharp differences of opinion, both rational and emotional, which revolve around the functional organizations that should be developed, and some of these differences center as much on such calorific words and phrases as *regimentation, socialized medicine, state medicine, public medicine, health insurance, un-American activities,* as on specific proposals.

Wage-earners and salaried workers must have protection against wage loss during periods of temporary or permanent disability; on this there is no important difference of opinion, but there remains yet to be reached full agreement as to inter-relations with medical care provisions, workmen's compensation, unemployment compensation, and old age and survivors insurance at state and federal levels of operation.

The objectives and the broad outlines of a national health program are only little in dispute, but the details and the specific contents present many issues. Within the boundaries of the program there are problems which raise profound questions concerning public and private relationships, the role of government in discharging public responsibilities, the expansion of public services at the expense of private domains. There are issues as to public support of professional education, and as to public and professional responsibilities for the quality of service subsidized or financed by public funds. There are large stakes concerned with preservation of vested interests. In short, there are the manifold complexities involved in the reordering of a social institution which vitally affects the life and welfare of every member of our society. A health program built on existing facilities must of necessity contain many compromise plans and provisions. It must embody internal devices for concurrent evaluation of its practices, for adjustment, and for change and improvement. Discussion and understanding are essential now that legislative action is impending.

The magnitude and the complexity of a national health program are great. The parts require careful coordination, and the whole needs to be seen in broad perspective. The objectives deserve thorough understanding. Yet understanding alone will avail little if, in the face of needs which are widespread and acute, study and contemplation continue to remain an alternative for action. There are many aspects of the program which no one can now wholly grasp, and there are many questions which no one can confidently answer. But among these the largest number are those which only experience can resolve, and no amount of cloistered study or factional dispute can serve as a substitute. The most costly experience is that which arises from inaction in the face of technological change and social need.

# AMERICAN EXPERIMENTATION IN MEETING MEDICAL NEEDS BY VOLUNTARY ACTION*

MARTIN W. BROWN†

## I

For many decades, various groups in this country have been seeking a solution to the several economic problems of medical care. But it is only in the past few years that people have been faced with a situation where the costs of illness can vary excessively. This problem of varying costs of illness arose as a result of the explosive expansion of medical science. Beginning more than 50 years ago and continuing to the present time, this proceeded without regard for the economic consequences. The development of medical institutions and equipment, the differentiation of medical knowledge into myriad fields of specialization, has been haphazard. This has resulted in numerous new services, charges for which are now found in the medical bill.

Where in the 1880's the doctor received almost 100 per cent of the expenditures for medical care, he now receives approximately 40 per cent[1] and this is divided between the general practitioner and a corps of specialists. But the doctors are not receiving less; the patients are paying more. When today's patient makes his first visit in any illness to the office of the doctor, he can have no idea what the ultimate cost to him will be. He knows that the visit will cost $2, $3 or $5. But he cannot foretell whether the doctor will call for laboratory tests, x-rays or special diagnostic work. He does not know whether the physician will recommend hospitalization and surgery. For each of these he must pay. The bill for medical care, composed of items for many different kinds of services, may total hundreds of dollars. Experience has indicated that the burden of these varying costs can be met by spreading them over a large group of people, each person paying his proportional share, in other words, by insurance. It is the cost problem that most of our current experimentation is designed to meet.

* This paper is devoted to a consideration of voluntary medical service plans. Its scope does not include consideration of the numerous experiments under governmental auspices or group hospitalization plans. While the latter are significant as illustrating a partial solution to present problems and have a definite place in the scene of American Experimentation, it has been left for following articles on these plans to develop.

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[1] FALK, KLEM & SINAI: THE INCIDENCE OF ILLNESS AND THE RECEIPT AND COSTS OF MEDICAL CARE AMONG REPRESENTATIVE FAMILY GROUPS (1933) PUBLICATION OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE, No. 26, 151, table 30.

This situation is far different from that which led to our first efforts to plan the distribution of medical service. Back in the 1880's several industries, particularly mining and lumbering, drew employees away from more settled communities into areas isolated from the conveniences of the larger towns and cities. These industries were, by their very nature, hazardous; income was generally low and irregular. Physicians and other medical personnel or agencies were loath to establish themselves in these isolated mining or lumbering camps as economic, professional and cultural inducements were lacking. Yet to make medical resources available was a matter of vital importance. This was effected by a relatively simple arrangement. A fund was accumulated by deductions from the employees' wages, and the money thus obtained was used to remunerate physicians hired by the companies to settle in these camps and serve the employees.[2] The problem that was solved by this device was that of making facilities available. It was in no way related to the problem of varying costs.

## II

American experimentation, seeking a solution for the problems created by the development of the science of medicine, has taken innumerable forms. The scope of present experimentation can best be illustrated by examination of the eight most illuminating plans. These are (1) The Ross-Loos Medical Group; (2) The Roanoke Rapids Community Service; (3) Stanocola Employees' Medical and Hospital Association; (4) The Spaulding Bakeries Employees' Mutual Benefit Association; (5) The Mutual Aid Society of the Consolidated Edison Plan; (6) The King County Medical Service Bureau; (7) The Saskatchewan Municipal Doctor System; (8) The plan of the Transport Workers' Union. The comparative study of plans for the extension of medical care, such as those listed above, will be facilitated by reference to the accompanying chart in which the points of difference in the various mechanisms are classified under six principal headings.[3]

CHART FOR THE COMPARISON OF METHODS FOR EXTENSION OF MEDICAL CARE*

| *A*<br>*Time of Payment* | *B*<br>*Method of Participation* | *C*<br>*Method of Financing* |
|---|---|---|
| 1. Non-payment | 1. Compulsory | 1. Fees |
| 2. Post payment installment | 2. Voluntary | 2. Insurance premiums |
| 3. At receipt of service | (a) Individual | 3. Taxes |
| 4. Periodic prepayment | (b) Group | 4. Philanthropy |
| | | 5. Employer contributions |
| | | 6. Contributed services (doctors in hospitals, care of indigent clients) |

* Conceived by Dr. Kingsley Roberts, Bureau of Cooperative Medicine.

[2] WILLIAMS, MEDICAL CARE THROUGH FIXED PERIODIC PAYMENTS (1932); BUREAU OF COOPERATIVE MEDICINE, MEDICAL CARE IN SELECTED AREAS OF THE APPALACHIAN BITUMINOUS COAL FIELDS (1939).

[3] To illustrate the use of the chart, the components of the Ross-Loos Medical Group Plan are, A4, B2(b), C2, D1, 2, 3, 4, 8, 10, E4, F7, while for the Municipal Doctor system are A——, B1, C3, D1, E1, F1(c).

| D<br>*Scope of Service Provided* | E<br>*Method of Distribution* | F<br>*Method of Administration* |
|---|---|---|
| 1. General Practitioner | 1. Solo General Practitioner | 1. Government<br>(a) Federal<br>(b) State<br>(c) Municipal<br>(d) County |
| 2. Specialist (including surgical) | 2. Solo Specialist | 2. Medical Society |
| 3. Diagnostic | 3. Panel with or without "unit" system. | 3. Profit insurance |
| 4. Hospital | 4. Group practice<br>(a) hospital<br>(b) private clinic | 4. Employer |
| 5. Special nursing service<br>(a) hospital<br>(b) home<br>(c) school<br>(d) visiting | | 5. Hospital Staff |
| 6. Dental | | 6. Private doctor group |
| 7. First aid | | 7. Entrepreneur |
| 8. Health conservation and education | | 8. Group Health Association |
| 9. Other institutional | | |
| 10. Drugs & Supplies | | |
| 11. Other | | |

*(1) The Ross-Loos Medical Group*

The Ross-Loos Medical Group was originally organized in 1929 in Los Angeles, California, to render medical service to the employees of the Department of Water and Power of the city. The service was expanded when contracts for service were signed with other employed groups and in 1936 the Group leased a four-story building to house the growing clinic.

Financial and professional arrangements between the clinic and groups of subscribers are negotiated by specially organized health committees in each group. All complaints and adjustments are made through these committees. At the present time, there are approximately 21,000 employed subscribers representing more than 110 different groups of persons, constituting with their families over 60,000 people.

The Group is owned and operated by a medical co-partnership of 19 of the 69 full-time staff physicians. The staff has its offices either in the main clinic or in one of the ten branch clinics located in the suburbs.[4] These facilities have been specially designed for the particular type of practice engaged in.

For $2.50 per month, the Clinic agrees to provide for the subscriber,[5] medical services of general practitioners, specialists and surgeons in the home, clinic, or hospital. Services also include laboratory work, x-ray services, physical therapy treatments, eye refractions, drugs and dressings and hospitalization. Dependents of members may receive all professional services at 50 cents for each office call, $1 for each resident call and other small charges for special procedures, such as $25 for a major operation. The average charges for service to dependents is 81 cents per month

[4] A branch clinic has been recently opened in San Francisco, details of which are not available as yet.
[5] Individuals may now subscribe for service at a $3 per month premium.

per family. The average of 15.8 office calls (excluding calls for operative procedures) per year per average family of 3.2 persons indicates the volume of service rendered.

*(2) The Roanoke Rapids Community Service*

In Roanoke Rapids, North Carolina, there is a community plan supported by the employees of three mills and two other local concerns. Each mill supplies and maintains a small clinic which serves as offices for seven of the ten available physicians. At the local hospital there are two full-time surgeons; and an ear, nose and throat specialist has his own office. The mills also support one full-time nurse.

For the services of the seven clinic physicians, the ear, nose and throat specialist and the visiting nurse, the employees of these concerns pay 25 cents per week. For the services of the two surgeons and for hospitalization, they pay an additional 25 cents per week. These premiums assure coverage for dependents as well as the employee. About 5,000 persons are covered by these arrangements. The premiums are collected by payroll deduction and are turned over by the concerns to the auditor for the companies. The latter keeps the books for the plan and distributes the funds collected. Before 1931 the concerns contributed half the fund. Since then they have limited their support. In 1931 the employees voted to increase their contributions to those noted above so that the service could be continued. A study[6] in 1930 of the services rendered revealed that among the persons covered, 1.8 visits per person were made per year, while among the remaining uninsured population only .4 visits were made.

*(3) Stanocola Employees' Medical and Hospital Association*

This association in Baton Rouge, Louisiana, is an organization of the white employees of the Standard Oil Company of Louisiana. It was first organized 15 years ago to provide medical service to the members and their families. These services now include medical care rendered by 11 full-time physicians (including two surgeons, an eye, ear, nose and throat specialist, a pediatrician and an anaesthetist), laboratory tests, x-ray and other diagnostic services. Hospitalization and private duty nursing benefits, when recommended by a member of the medical staff, are included up to a maximum cost of $250 for a single illness.

The Association owns a clinic building which it purchased in 1938, has its own board of directors and officers, and is nominally independent of the Standard Oil Company. Membership in the Association is voluntary, yet about 90 percent of the eligible group has joined. Dues are $3 per month. In January 1928, the Board was given permission to levy three special assessments of $3 each in any calendar year. This authority is exercised twice a year.

In 1930 the Association was incorporated, and each member is required to purchase a share of stock. Funds so received constitute the capital and reserve funds of the Association.

[6] Falk, Griswold, Spicer, *A Community Medical Service Organized under Industrial Auspices in Roanoke Rapids, North Carolina.* (1932) PUBLICATION OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE, No. 20.

*(4) The Employees' Mutual Benefit Association of the Spaulding Bakeries*

This association in Binghamton, New York, was organized in 1930 for the purpose of providing cash benefits and medical care and hospitalization during sickness. The Association is divided into plant divisions, and a Board of Trustees appointed by the company is in charge of the administration of each division. The funds of each division are administered separately. The dues paid by employees vary according to their weekly wage from a minimum of 20 cents per week to a maximum of 45 cents. The company contributes about $2 per month for each employee, as well as room and clerical assistance.

Upon application to the Trustees, a member may receive benefits as follows: $3 for house calls and $2 for office visits up to a maximum of $50 in any one year; designated cash benefits for surgical procedures such as a $100 limit for major operations. A hospital benefit of $3 per day not to exceed $90 is provided. Members have free choice of any physician or hospital in the locality. The five year average cost has been $25.47 per employee per year. Dependents are included for $1 per family per month with expenditure limited to $50 a family in any one year.

A supervisory committee of three physicians, one appointed by the medical society, passes on medical bills whenever there is a question of exorbitant charges, padding or unnecessary services.

*(5) The Mutual Aid Society of the Consolidated Edison Company*

The present plan of the Consolidated Edison Company in New York City was developed in 1935. It is intended to cover all the 40 to 50,000 employees of the company and its affiliates. The employees earning less than $46 per week are organized into a voluntary Mutual Aid Society. The company deducts ⅝ of 1 percent from weekly salaries (average $32.40) and itself contributes additional sums so that an annual fund of $1,100,000 is established to pay for care required by members during the year. The financial affairs of the Society are administered by the Company.

The Society contracts with a limited number of physicians to furnish home and office care. It has also arranged with certain hospitals to provide unlimited hospital services in wards at $4 per day. The physicians and surgeons who perform the services are paid on a fee for service basis according to a minimum fee schedule. The Society has ruled that no physician shall receive more than $1,200 per year from payments for services rendered to members.

*(6) The King County Medical Service Bureau and Corporation*

The King County Medical Service Bureau in Seattle, Washington, is one of fourteen developed to meet a situation created by a provision of the State Workmen's Compensation Law permitting private corporations to contract with employers to render medical service. The Bureau is a voluntary association of physicians who have agreed to furnish services to the King County Medical Service Corporation. This corporation is a non-profit organization that contracts with employers to provide medical and surgical care, hospitalization, nursing and ambulance services to the

employees. The Corporation in turn contracts with the physicians of the Bureau, with hospitals and other agencies for the provision of the services. About 32,000 employees covered by contract receive services from the 450 physician members of the Bureau.

The Corporation sells two contracts, one for compensable injuries and the other for sickness and non-compensable injuries. In the case of the latter contract, the employee pays the premium through payroll deduction. The premiums range from $1.25 to $1.75 per month.

The physicians of the Bureau and the Corporation agree upon a fee schedule. Payments are made to the doctors under the unit system.[7] The organization is administered by a medical director and a sales director who runs the office and sells contracts. A medical audit committee examines the physicians' monthly statements of services rendered.

*(7) The Saskatchewan Municipal Doctor System*

In the Province of Saskatchewan, Canada, 84 rural municipalities, corresponding to a county in the United States, furnish medical services to the inhabitants at municipal expense. In addition, 54 villages and four towns employ municipal physicians. Altogether 179,254 persons or 19 percent of the provincial population live in communities where medical services are paid for through general taxation.

The salaries paid to the municipal physicians range from $2400 to $6000 per annum, the average being $4,000. Where the salary is comparatively low, the doctor is usually permitted to charge for an initial home call during an illness or for special services such as a confinement. However, under the terms of the average contract between municipality and physician, the doctor is to provide general medical services and obstetrical care and to perform minor surgery. He also acts as public health officer. Out of the salary paid the physician, he must maintain an office and pay his own expenses.

The system is primarily a method of obtaining or retaining resident physicians in the municipalities. It has also come to be regarded as a simple method of arriving at a more equitable distribution of the costs of medical care.

In 11 municipalities, physicians are subsidized by annual grants up to $1500 per year. In 59 municipalities and 7 towns, hospital care and treatment is provided. The system is being extended to the Provinces of Alberta and Manitoba.

*(8) The Plan of the Transport Workers' Union*

The New York Local Transport Workers' Union have recently instituted a medical program for its members. The service will be financed primarily from the union's treasury and the receipts from two benefits each year. The estimated cost of providing general practitioners' and specialists' care to the 55,000 members is $170,000. The services, free to members, are rendered by a panel of 52 full-time physicians and

[7] Under this method, each service is allotted a specified number of units. The total number of units of service during a month is divided into the amount of money available to pay medical bills, and each participating physician is paid the resulting unit value for the units of service he has rendered.

specialists. Each general practitioner will have a list of about 1000 members. The doctors will be paid on a salary basis but will maintain their own offices rather than practice as a group. The services will be administered by a committee of union officials.

## III

The eight plans outlined in the preceding section reveal the differences on fundamentals that prevail on the scene of American experimentation. These are: (1) Should membership in a plan be limited to a specific group in the population as employees of a common employer, members of a labor union, a club or fraternal order, or should it be open so that any resident of the community may associate himself with it and avail himself of its advantages? (2) Should benefits be cash reimbursement to defray expenses for medical care or the medical care and attention itself? (3) Should the services be rendered by a group of full-time physicians utilizing common offices and equipment, by a restricted panel of physicians each maintaining his own office, or by any physician in the community who desires to participate? (4) Should the physicians be remunerated on the basis of salary or fee for service?

First, should membership or participation in the plan be limited to a specific group in the population or should it be open so that any resident of the community may associate himself with it and avail himself of its advantages? Generally speaking, company or industrial plans have been set up for the employees of the concern and their families. The plans of the Roanoke Rapids Concerns, Standard Oil of Louisiana, Spaulding Bakeries, Consolidated Edison and the Transport Workers' Union proceed on this basis. The Ross-Loos Medical Group entered into subscription contracts only with employed groups until a year ago when individual enrollment was added. This is still the situation in the case of the King County Medical Service Bureau.

The establishment of associations especially organized for the purpose of meeting medical care problems and operated independently of any particular industrial concern is meeting with increasing favor on the part of employers. The development of industrial plans has imposed burdensome tasks upon them. They are generally responsible for the administration, and in most cases contribute sums of money to the plans' funds. That the arrangements may be made in the name of an Employees' Mutual Benefit Association[8] does not alter the situation. Further, it is becoming more and more clear that the administration of these programs is a specialized field requiring personnel trained for that purpose. Another factor stimulating the change of attitude of employers is the growth of labor unions which look upon employee associations with disfavor. These, they feel, smack of company unions and paternalism.

The second question is: Should benefits be cash reimbursement to defray expenses

[8] In most cases, the arrangements for medical care are but incidental to other activities of these associations.

for medical care,[9] or the medical care and attention itself? Of the eight plans noted in Section II, only that of the Spaulding Bakeries pays cash benefits to defray medical expenses.

The problem in the case of cash benefits to defray medical expenses is that adequate data which can be used to estimate claims for such benefits are not available. Yet premiums must be fixed and out of the fund so accumulated must be paid claims according to a fixed fee schedule. As a result, plans of this type have had a precarious existence. They are most successful in industrial concerns where the employer can contribute to and replenish the funds as may be necessary. Several proposals have recently been made to establish such plans independent of any employer and with an open membership. These proposals have generally been made subsequent to the endorsement in 1938 of this form of health insurance by the A.M.A.

Evidence would tend to indicate that the present trend however is towards service benefits. Many Employee Mutual Benefit Associations are adding benefits in service to cash benefits during periods of disability.[10] Many state and county medical societies have advanced proposals for benefits in service despite the position of the A.M.A.

The third question is: Should the services be rendered by a group of full-time physicians utilizing common offices and equipment, by a restricted panel of physicians each maintaining his own office, or by any physician of the community who desires to participate?

The A.M.A. takes the position that any arrangement for the distribution of medical service must be so devised that any physician in the community may, if he so desires, associate himself with the plan. The A.M.A. further favors fee-for-service remuneration of physicians. Advocates of group health plans on the other hand favor the distribution of services through groups of physicians practicing as a unit along the lines indicated by the Mayo Clinic.

A third type of arrangement is sometimes used and this is illustrated by the plan of the Consolidated Edison Company where participation by physicians is restricted and "free choice" does not exist. Each physician associated with such a plan maintains and practices in his own office independently of the other physicians on the panel. The arrangements of the Transport Workers' Union are also of this type. Such panel arrangements are generally to be found in metropolitan areas where a wide spread of population makes service from a central point or from a single group practice clinic a difficult procedure. At the present time, many of the leaders of the medical profession favor group medical practice as the only medical procedure where the physician and the patient can take advantage of all that modern medical science has made available.[11]

[9] While a great many industrial plans pay fixed sums per week during periods of disability, the objective of such arrangements is to compensate for loss of wages during the period of disability, and, therefore, bears no relation to the specific problems of varying costs for medical service or the availability of facilities.

[10] NAT. IND. CONF. BD., HEALTH INSURANCE PLANS: MUTUAL BENEFIT ASSOCIATIONS, STUDIES IN PERSONAL POLICY No. 9A (1938).

[11] Peters, *Free Experimentation in Meeting Medical Needs, A Professional View*, Address Delivered at

Closely related to the issue of free choice or group practice is that of how shall the doctor be paid? There are two fundamental procedures that are utilized. The doctor may be paid for each unit of service rendered, being assured either payment according to a fee schedule or out of a fund in proportion to the value of services rendered (King County Medical Bureau). The second is to pay the doctor a fixed sum per year, month or week, regardless of the volume of service. This might be paid on a straight salary basis for full-time or part-time work or on a capitation basis for part-time services, *i.e.*, a fixed sum per person per year regardless of the volume of services rendered to any particular person. In the case of a plan paying cash benefits in reimbursement of incurred medical expenses, the method of payment is necessarily fee-for-service. But in the case of a plan where the benefits are the medical services, either of the procedures is possible. The "unit" system[12] was developed to overcome the lack of actuarial data which may result in a hazardous financial career for the plan. This technique has the advantage of fixing an upper limit of expenditures so far as the plan is concerned. This device is utilized in plans with free choice of physician and in many panel plans. Group practice plans almost universally pay physicians on a salary basis. The capitation arrangement is particularly adapted to panel plans.

The value of the capitation arrangement, which has not found particular favor in this country although it is common practice in European compulsory health insurance schemes, is that it has the great advantage of eliminating the necessity for a check and audit of physicians' services. Such check and audit are essential in the administration of free choice or panel plans paying on a fee-for-service basis. Experience has indicated that unless the statements of physicians as to care rendered are investigated and examined to determine the extent of their responsibility for unnecessary service (which the patient also must share) funds of the plans will be depleted by payment for such services.

In the case of unit system payments, although the abuse of unnecessary calls and treatments would not increase expenditures, if the check and audit were not made, payments for each unit of service would gradually become lower until the well-trained and well-equipped physician could no longer afford to render services under the plan and would have to separate himself from it. Should this happen, poorer physicians would remain and the quality of service would be inevitably lowered.

At the First Annual Convention of Group Health Plans held in New York City last July, the various groups represented undertook the establishment of a national Group Health Federation. The inauguration of an active program by this federation may materially affect the course of future developments in the field of experimentation in meeting the medical needs of people with low incomes.

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First Annual Convention of Group Health Plans; Cabot, Address delivered at N. Y. Herald Tribune Forum, N. Y. *Herald Tribune*, Oct 30, 1938; Winslow, *Medical Care for the Nation* (1939) 28 YALE REVIEW 501; Sigerist, *Socialized Medicine* (1938) 27 YALE REVIEW 463; Roberts, *Medical Cooperatives*, HEALTH AND HYGIENE, October, 1937.

[12] Defined in note 7, *supra*.

# ETHICAL AND LEGAL RESTRICTIONS ON CONTRACT AND CORPORATE PRACTICE OF MEDICINE

JOSEPH LAUFER*

In response to profound social, economic and technological changes experimentation with new forms[1] of medical practice has begun on a nationwide basis. These new forms might be described as deviations from a traditional pattern which was molded by a close, confidential relationship between doctor and patient, entered into and continued by virtue of a "free choice" on both sides, and based economically upon a fee charged for an individual service. Where the patient is met no longer by an individual physician but by a group, usually specialists united in a "clinic," the first deviation from the pattern is present: *i.e.*, "group practice." Here the economic basis of the relationship is still the individual fee. A second deviation, often combined with, but distinguishable from, the first, is the intervention of a third party, an individual or organization agreeing with a physician or a group of physicians for the future treatment of a group of patients. The patient no longer contracts directly with the physician. Practice carried on pursuant to such third-party agreements is termed "contract practice"[2] by the medical profession. It is these agreements which form the basis of most medical care plans providing for risk-sharing prepayment by groups of patients.

These plans utilizing either "group" or "contract" practice or both, must run the gantlet of restrictive rules derived from medical ethics or law. Of the major restrictions two will be considered here: the ethical rules governing "contract practice," and the legal rules governing "corporate practice of medicine."

The ethical and the legal rules alike spring from a time when the traditional pattern was the universal ideal. Their main purposes were to protect the public from quackery and also to preserve the traditional detachment of the profession from commercialism. The danger of lay and even professional efforts to import commercial methods into the medical field has been a real one in the past, and it would be idle to

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[1] See, generally, MEDICAL CARE FOR THE AMERICAN PEOPLE: FINAL REPORT, COMM. ON COSTS OF MEDICAL CARE (1932); NEW PLANS OF MEDICAL SERVICE (Julius Rosenwald Fund, 1936); AMA BUREAU OF MED. ECON., NEW FORMS OF MEDICAL PRACTICE (undated); BERNHEIM, MEDICINE AT THE CROSSROADS (1939); Note, *Group Practice versus the AMA* (1938) 47 YALE L. J. 1193.

[2] See PRINCIPLES OF MEDICAL ETHICS OF THE AMA, c. III, art. VI, §2, published in AMERICAN MED. DIRECTORY (15th ed. 1938) 15.

assume that the risk no longer exists.[3] Now, as then, the ethical rules and the medical practice acts fulfill an important task in thwarting such anti-social efforts. But the problem today is more difficult. The courts, in interpreting the medical practice acts face a dilemma: too restrictive an interpretation may block socially desirable experimentation, too liberal rulings may open the door to commercialized schemes. It is important, therefore, in this period of transition, to examine the legal principles involved, and the bases for their interpretation. The same, *mutatis mutandis,* holds true of the professional ethics of the medical profession. The latter are embodied in the code of ethics of the American Medical Association and constitute the special law of a group, made, interpreted, enforced by the group or its subdivisions. The code was adopted[4] in its present form in 1912 by the AMA's legislature, the House of Delegates, and entitled "Principles of Ethics." It is applied and interpreted in the grievance committees of the component county and constituent state societies. From these committees, which are, in effect, professional courts, appeal lies to the Judicial Council of the AMA, the medical Supreme Court. That rulings and decisions of these professional courts do not lack effective sanction is evident from the fact that the ultimate penalty, expulsion[5] from his professional organization, may often spell economic ruin to the expelled member, for he may no longer be able to treat his patients in good hospitals.

Seldom have courts interfered with this professional jurisdiction if the defendant has been accorded a fair hearing. This non-interference is based on the notion that private organizations, as the AMA, may lay down rules[6] which must be followed by those who wish to be or remain members. The only limitation on this group autonomy is that the rules may not run counter to "public policy" as conceived by the reviewing court.[7] But these professional rules have a wider importance. They have often a decisive bearing on judicial decisions. Legal reasoning is seldom, if ever, self-sufficient or self-sustaining. It draws its driving force and persuasion from other and deeper sources, and one of these is ethics. Thus, in the litigation of questions involving the practice of medicine the ethical rules may often be more decisive than mere logical, legal argumentation. It is against this backdrop of judicial and professional power and responsibility that the following discussion should be viewed.

## ETHICAL RESTRAINTS ON CONTRACT PRACTICE

The history of contract practice[8] can be traced back over a period of almost 90 years. It originated as early as the middle of the last century when railroads, mining

[3] See MEDICAL CARE FOR THE AMERICAN PEOPLE, *supra* note 1, at 47.

[4] (1912) 58 J. A. M. A. 1907.

[5] See cases of recent expulsions cited in Note (1938) 47 YALE L. J. 1193, n. 14.

[6] *Cf.* Weyrens v. Scotts Bluff County Med. Society, 277 N. W. 378 (Neb. 1938); Harris v. Thomas, 217 S. W. 1068 (Tex. App. 1920). As to rules on contract practice, see Irwin v. Lorio, 169 La. 1090, 126 So. 669 (1930); Porter v. King County Med. Society, 186 Wash. 410, 58 P. (2d) 367 (1936).

[7] See cases cited *supra,* note 6.

[8] See, generally, LELAND, SOME PHASES OF CONTRACT PRACTICE, (AMA Bureau of Med. Econ., 1932); LELAND, *Contract Practice,* PROCEEDINGS OF THE ANNUAL CONGRESS OF MEDICAL EDUCATION, HOSPITALS

and lumbering industries met the need of providing medical care for their employees under "frontier" conditions by hiring salaried physicians. The practice spread. When in the beginning of this century workmen's compensation laws began to be enacted, some states built the existing pattern of this industrial contract practice into their own scheme of reform, giving it not only formal legal sanction but new impetus. The tendency towards expansion was further strengthened by the steady growth of industrialization. Another, independent root is found in mutual benefit associations in the cities which furnished their members hospitalization and medical care for which they paid in form of membership fees.

From the very outset, the medical profession raised grave ethical objections against this method of supplying medical care, especially within the industrial field where the danger of abuses was greatest. Underpayment of the contract physician, restriction of free choice, insufficient treatment, lay control, interference with the confidential doctor-patient relationship, underbidding between physicians and generally unfair competition with the independent practitioner were mainly complained of. Intimations[9] were made that contract practice was justifiable only in cases of necessity, *i.e.*, where independent practitioners are not available. The enactment of the workmen's compensation laws did not silence these complaints since they did not prevent the continuance of some of these abuses in this field into the present time as a recent comprehensive study indicates.[10]

Despite the abuses, actual or possible, connected with contract practice, it spread far beyond the industrial field with its special problems. Prior to 1912, however, the code of ethics had not dealt specifically with it. Whatever objections were raised at that time, were based on more general principles. But when in 1912 the present version of the "Principles of Ethics" was adopted,[11] a new section[12] was inserted under the heading of "Contract Practice" which provided:

"It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patients or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession."

This rule remained unchanged until 1934. The emphasis upon two major objections, danger of inadequate service and of unreasonable competition among physicians, illustrates clearly the dual aspect of the problem in which ethical and economic considerations are interwoven. But the question was not settled by this broad rule. Contract practice continued to expand. In 1939, the AMA's authority on contract practice reported[13] that there are:

"75 group hospitalization plans, some 54 hospital insurance companies, . . . at least 2000 medical care services, at least 500 medical and hospital benefit organizations, about 24

AND LICENSURE OF THE AMA, 1937, 75, 82 (hereafter cited as "Proceedings"); ECONOMICS AND THE ETHICS OF MEDICINE (AMA Bureau of Med. Econ., 1937).

[9] *Cf.* LELAND, CONTRACT PRACTICE (AMA Bureau of Med. Econ. 1932) 17.

[10] DODD, ADMINISTRATION OF WORKMEN'S COMPENSATION (1936) 490-493.

[11] *Supra* note 4.

[12] *Supra* note 2.

[13] Leland, *Trends in the Distribution of Medical Care*, PROCEEDINGS, 1939, 71.

union sick benefit funds and fraternal organizations, . . . about 300 private group clinics, at least 300 college and university students health services, . . . an unknown number of plans designed to assist portions of low income farm families . . .; in addition, the physicians themselves are operating more than 150 medical care plans and are considering the organization of 120 more. . . ."

This growth of contract practice was accompanied within the profession by discussion and dissension mounting with the stress of the depression years. The Judicial Council had occasion to warn[14] that "many of the members of the AMA are straining at the ethical leashes which curb their desires." Finally, the need for further development of the rule led to a number of amendments adopted in 1934.

One of them, though general in form, has a direct bearing on contract practice. It provides, under the title "Direct Profits to Lay Groups":[15]

"It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy."

This section, aimed against commercial exploitation of medical services, would clearly not prevent non-profit organizations from engaging in contract practice even if they should accumulate an operating surplus which would be used as a reserve.

More pertinent to the specific problem, however, is another amendment[16] which provided:

"By the term 'contract practice' as applied to medicine is meant the carrying out of an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, to furnish partial or full medical services to a group or class of individuals on the basis of a fee schedule or for a salary or a fixed rate per capita.

"Contract practice *per se* is not unethical. However, certain features or conditions if present make a contract unethical, among which are: 1. When there is solicitation of patients, directly or indirectly. 2. When there is underbidding to secure the contract. 3. When the compensation is inadequate to assure good medical service. 4. When there is interference with reasonable competition in a community. 5. When free choice of a physician is prevented. 6. When the conditions of employment make it impossible to render adequate service to the patients. 7. When the contract because of any of its provisions or practical results is contrary to sound public policy.

"Each contract should be considered on its own merits and in the light of surrounding conditions. Judgment should not be obscured by immediate, temporary or local results. The decision as to its ethical or unethical nature must be based on the ultimate effect for good or ill on the people as a whole."

This amendment removes any doubt that hitherto may have existed as to the ethical status of contract practice generally. It is now impossible to deny ethical

[14] Report of the Judicial Council (1934) 102 J. A. M. A. 1497.

[15] Now c. III, art. VI, §5, *supra* note 2.

[16] Now c. III, art. VI, §3, *supra* note 2.

recognition to an agreement simply because it involves contract practice. To that extent the provision restricts complementary rules[17] which component and constituent societies might adopt. Since they may not contradict the rules of the AMA, any blanket provision[18] against contract practice would be unconstitutional and void. It is likewise to be noted that contract practice has not been restricted to "emergency" situations where the "usual conditions of employment," *i.e.*, an individual doctor-patient agreement, cannot be created.

This shift in position—essentially a change in emphasis—suggests a need to resolve a conflict of ethical ideals or values. The ideal of the individual doctor-patient relationship conflicted with the ideal of extending medical care to all in so far as that could be achieved only by contract practice. It is a familiar function of ethical rules to guide choice where a dilemma is unavoidable. They fix a scale or hierarchy of values which changes with changing times and circumstances. Thus, precedence is now accorded the extension of medical care through contract practice but only if certain basic conditions, associated with the individual relationship ideal, are complied with. It must be noted, however, that this enumeration of "features or conditions" which taint an agreement as unethical, is not exclusive. Some are of a kind determinable by facts which are more or less easily ascertainable or measurable. Solicitation, underbidding, inadequate compensation, perhaps even presence or absence of free choice of physician are among them. But others are far less tangible. When is there "interference with reasonable competition in a community"? What are the standards of reasonable competition? When, furthermore, is a contract contrary to sound public policy? May that be the case even if all the preceding objectionable features have been eliminated? The code gives[19] a general hint: "each contract should be considered on its own merits and in the light of surrounding conditions. Judgment should not be obscured by immediate, temporary or local results. The decision as to its ethical or unethical nature must be based on the ultimate effect for good or ill on the people as a whole." This caveat raises the question whether final effects can be determined other than in terms of local results which, as the "Principles" warn, should be disregarded as "obscuring the judgment."

In 1937 a further amendment[20] was added. It provided:

> The phrase "free choice of physician" as applied to contract practice is defined to mean that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patient and physician when no third party has a valid interest or intervenes. The interjection of a third party who has a valid interest or who intervenes does not *per se* cause a contract to be unethical. A "valid interest" is one where, by law or necessity, a third party is legally responsible either for cost of care or for indemnity. "Intervention" is the voluntary assumption of partial or full responsibility for medical care. Intervention shall not proscribe endeavor by component or constituent medical societies to maintain high quality of service rendered by members serving under

[17] *Cf.* warning in the Report of the Judicial Council (1937) 108 J. A. M. A. 1539.

[18] But *cf.* Ill. State Med. Society ruling that lodge contract practice is unethical, (1937) 109 J. A. M. A., Organizational Section, 84b.

[19] *Supra* note 16.

[20] Now c. III, art. VI, §3, *supra* note 2.

approved sickness service agreements between such societies and governmental boards or bureaus and approved by the respective societies.

The provision, rather obscurely phrased,[21] seems to indicate that the ideal of freedom of choice has been abandoned in a case where "a third party has a valid interest or intervenes."[22] The third party thus privileged must have either of the following qualifications (1) it must be legally responsible for the patient, or (2) it must have agreed to a voluntary assumption of partial or full financial responsibility. But when may a party, by law or necessity, be legally responsible? It can obviously not mean when a party has bound itself by *contract*. For this would permit restriction of "freedom of choice" in all cases of contract practice and thus render the entire provision nugatory. The elimination of that responsibility based on contract would leave governmental departments, subdivisions of the states, perhaps employers under the workmen's compensation laws, as such privileged parties for their responsibility rests directly on law. This answer does not cover the case where a party is legally responsible "by necessity." Presumably, the phrase aims at a situation where a legal duty to give medical care arises only if the patient cannot get it otherwise, as, *e.g.*, the lumbering company might be responsible for a woodsman sent to a remote lumber camp.

When is there a "voluntary" assumption of financial responsibility? Again, it cannot mean a party that is not obligated to assume financial responsibility but assumes it of its own accord, for this interpretation would permit all contract schemes of private organizations to restrict "freedom of choice" which cannot be intended. The term "voluntary" would rather point to charitable institutions which render their services gratuitously. This interpretation accords with current usage of the term by the medical profession.

If this interpretation is correct, the amendment relaxed the rules as to "freedom of choice" somewhat in favor of governmental and charitable contracts, probably also in the situations covered by the workmen's compensation acts. It has tightened them, however, in all other agreements, by requiring practically absolute freedom of choice. It is very doubtful whether many of the plans actually operating comply with this strict requirement. It must be further noted that even in plans where this freedom is absolute, the very existence of the plans leads to an important qualification: under many plans, the patient may, for purposes of control, be brought in contact with a supervising physician. This is especially true when serious and costly operations are contemplated. If plans, based on private initiative, are to succeed there may be need for some form of approach to the public. Dignified solicitation[23] may

[21] No official comment was published at the time of adoption. See (1937) 108 J. A. M. A. 2225.

[22] The statement that the "interjection of the third party" does not *per se* make a contract unethical, would be a needless repetition of the general principle that contract practice is not unethical *per se* unless it means that in these cases even the absence of free choice will not render the contract unethical *per se*.

[23] *Cf.* PRINCIPLES OF MEDICAL ETHICS, c. III, art. 1, §4: "Solicitation of patients by physicians as individuals, or collectively by groups by whatsoever name these be called, or by institutions or organizations, whether by circulars or advertisements, or by personal communications, is unprofessional. This does not prohibit ethical institutions from a legitimate advertisement of location, physical surroundings, and special

have to be recognized within clearly defined limits. These illustrations show that the recognition of contract practice will raise new and difficult ethical problems.

The present rules are doubtless not the ultimate answer. As they stand, it must be admitted that the grant of discretion to the grievance committees is, for purposes of administration, unlimited. The final control over any agreement seems to be left with the local committees or state appeal boards which may or may not seek advice of the Judicial Council. Formal appeals to this body, as contrasted with informal inquiries and replies, seem to be rare. The comparative lack of publicity given to these "internal affairs" prevent ascertainment of the application of the rules on "contract practice" to individual cases. Litigation over these matters in ordinary courts is uncommon and as long as the courts feel that these rules are not violating "public policy," litigation would seem useless.

### LEGAL RESTRICTIONS ON THE "CORPORATE PRACTICE" OF MEDICINE

The corporate device[24] is frequently encountered in the sphere of medical activities. Proprietary, charitable and university hospitals, where patients are treated by salaried physicians, have long been familiar. With the spread of industrial contract practice, hospitals were built by physicians engaged therein, and organized as corporations. Large industrial corporations, railroads, etc., set up their own hospitals and engaged medical staffs for their employees. More recently, the device has been used for purposes of organizing group practice in the form of incorporated clinics requiring capital investment by the associated doctors. These "plant" investments have increased with the ever-growing need for complicated, expensive equipment. In addition, expected or actual advantages under the tax laws, convenience of transfer in the case of personnel changes, avoidance of risk of liability for malpractice incurred by colleagues, continuity of the corporate existence, all such considerations may have contributed to the choice of this form so familiar to the business world.[25]

Many of these "clinics" dealt with the individual patient as would an individual practitioner. Some however, engaged in either industrial or general contract practice. Laymen organized corporations for profit which sold medical service contracts to the public. The services were to be supplied by doctors who had contracted with the corporation. On a higher plane, insurance companies began to write health policies providing either for the payment of a doctor's bill or the supply of medical services in kind. To the familiar incorporated fraternal or mutual benefit organizations, which included medical services among their benefits, have recently been added nonprofit cooperatives organized by lay groups for the specific purpose of supplying their members with medical care on a prepayment basis.

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class—if any—of patients accommodated." See also proposal to permit advertising of plans sponsored by state societies (1938) 111 J. A. M. A. 1210, 1215.

[24] See, generally, 1 FLETCHER, CORPORATIONS (Perm. ed. 1931) §97, 6 *id.* §2525; Davis, *Do Corporations Practice Medicine?* PROCEEDINGS 1932, 88 *et seq.*; Warnshuis, *The Practice of Medicine by Corporations* PROCEEDINGS 1932, 72; Levy and Mermin, *Cooperative Medicine and the Law* (1938) 1 NAT. LAWYERS GUILD Q. 194; Note, *Right of Corporation to Practice Medicine* (1938) 48 YALE L. J. 346; Notes (1939) 7 GEO. WASH. L. REV. 120; (1939) 37 MICH. L. REV. 961; (1939) 17 N. C. L. REV. 183.

[25] PRIVATE GROUP CLINICS: COMM. ON COSTS OF MEDICAL CARE, Pub. No. 8 (1931) 19, 20.

Despite this widespread use of the corporate device its legal status is by no means clear. The corporation statutes which usually provide that a corporation may be formed for any "lawful" purpose do not give an explicit answer since they throw no light on the "lawfulness" of the purpose. The legality of the purpose must depend on the applicability of the medical licensure acts. A literal reading of their provisions[26] indicates that they were aimed to regulate only the conduct of individuals engaging in medical activity. As they do not say explicitly what shall be the effect of the employment of such an individual by a corporation, there results a "gap" in the law which must be closed, in the absence of specific legislative regulation, by judicial interpretation. In other words, the problem is reduced to one of public policy to be determined by the courts.

Any examination of this policy problem calls for inquiry into the considerations governing the regulation of the professions. Basic among these is the grave difficulty raised by the professional man's tremendous power over the lay client. In ordinary dealings, the layman's common sense and experience suffice to check undue encroachments on his interests by the other side. This check is absent when he deals with professional men to whom, often enough, his health or economic existence must be entrusted; whatever the layman's experience may be, the lawyer's or physician's conduct is, to a large extent, beyond the reach of his judgment. Here, the "policing" function of the licensure statutes fulfils an important task. Unfit practitioners are kept out and those who are admitted are subjected to legal supervision, supplemented by professional discipline. Why then should the appearance of a corporation in the professional field create difficulty, provided only duly licensed physicians or lawyers are entitled to act as its agents? They will be subjected to the double supervision exercised over the independent professional man: by state authorities under the licensure acts, by professional bodies under the ethical codes. However, this reasoning overlooks one fact: both licensure states as well as enforceable rules of ethics reach or "police" only the most egregious offenses committed in the wide area of professional activities. The remainder is and must be left to the conscience of the individual. As he faces the ever-present temptation of furthering, without risk of discovery or punishment, his own interests over those of an unwitting client, ethical rules are expected to check his desires. Experience has shown that this check may prove too weak, but its necessity and average efficacy cannot be doubted. It is here that the appearance of the corporation raises a real problem. By the introduction of a third party, an outside interest, the strain on the individual is increased. For the normal temptation has been heightened as the professional man's own interest, hitherto exclusively personal, becomes weighted by the existence of the third party. He may now consciously or subconsciously subordinate the client's interest even where he would otherwise not have done so. His loyalty is divided.[27] In this regard,

[26] See, *e.g.*, N. C. CODE (Michie, 1939) c. 110, art. 1.

[27] See, *e.g.*, People *ex rel.* State Bd. of Med. Examiners v. Pac. Health Corp., 12 Cal. (2d) 156, 158; 82 P. (2d) 429, 430, (1938); Dr. Allison, Dentist, Inc. v. Allison, 360 Ill. 638, 642, 196 N. E. 799, 800 (1935); Neill v. Gimbel Bros. Inc., 330 Pa. 213, 219, 199 Atl. 179, 181 (1938).

it is obvious that the objections to corporate practice are not overcome by pointing to the legal and professional supervision over its licensed agents.[28] For these "external" safeguards do not operate within the sphere of individual motivation where their sanctions are unenforceable.

To the problem of the effect of the corporate employment on the practitioner's motivation must be added a second problem. It arises from the fact that corporate organization necessarily implies delegation of functions. Even if usually strictly medical functions, as surgery, etc., are left to licensed physicians, there is a penumbra of activities usually reserved to the practitioner in independent practice but likely to be delegated to lay personnel in a corporation. Certainly, a point may be reached where this delegation is clearly undesirable. Where is the line to be drawn? Should a lay board be delegated to impose general conditions on treatments to be rendered? What, if the same function is entrusted to a board of physicians? Can the conclusion of the agreement, fixing of fees, extension of credit thus be delegated? Obviously, any delegation made to laymen will exempt conduct from the influence of medical ethics as these rules apply to the physician's entire conduct whether technically practice or not.

To seek a simple solution for both problems in an outright condemnation of medical services rendered within a corporate framework, as many dicta seem to indicate,[29] is, of course, possible. This position, however, would disregard substantial distinctions in the types of interest presented in corporate form. Three types of corporations might here be differentiated.

A. The first type would include those corporations where the interest of the corporation is opposed to that of the patient only in a limited sense: any services to him will necessarily reduce the amount of services available to the class of patients which it serves. Here might be grouped: (a) charitable institutions of every description, (b) industrial organizations[30] where a paternalistic entrepreneur has allotted a budget for medical care of his employees; (c) incorporated fraternal and benefit organizations, (d) the recent group health organizations on a cooperative basis.[31] The third interest presented by the corporate device in the last two instances may, in disregard of the corporate entity, be considered as identical with that of the patient as a member of the organized group.

B. In the second type of corporation the interest of the entity does not essentially differ from that of the individual licensee. Its chief representative[31a] is "group practice" carried on in the form of an incorporated clinic. The disregard of the corporate entity would reveal, not the identity of patient and corporation, as in the previous illustration, but of physician and corporation. As long as the medical control is unimpaired, all responsible officers are within the sphere of professional, *i.e.*, ethical, motivation.

[28] *Contra:* Note (1938) 48 YALE L. J. 346, 348, 350.

[29] See the numerous cases cited 102 A. L. R. 343 (1936); 103 A. L. R. 1240 (1936); 119 A. L. R. 1290 (1939).

[30] Here, the rendition of medical services within a corporate framework is merely incidental to an economic enterprise with a wholly different main purpose.

[31] See Group Health Ass'n v. Moor, 24 F. Supp. 445 (D. C. 1938).

[31a] Another is the "one-man corporation." For examples, see the last two cases cited in note 45, *infra.*

C. The third type comprises lay-controlled business corporations, admittedly organized for profit, insurance companies, etc. Here, plainly, any service rendered to the patient may reduce the possible profit margin of the corporate enterprise, a "third interest" which is alien to doctor and patient alike and which is characterized by the need for profits and return of invested capital. This basic need of its corporate life must condition all its relations and will tax greatly the motivating strength of the ethical rules even where there is complete absence of lay interference with medical activity. Economic realities need no tangible medium to assert themselves.

It will be realized that this classification is only tentative.[32] In reality, the lines will often be blurred. The industrialist who makes profits[33] on the contributions exacted from his employees for medical care, the "medical group" operating with high pressure business methods, are ready illustrations. Nonetheless, the attempted classification is based on real distinctions which reflect varying degrees of strain on the practitioner's motivation and of impairment of the doctor-patient relationship. The problem remains whether these distinctions may offer standards for future judgments which will carefully discriminate between corporation and corporation.[34]

The legal approach to this question has been made in terms of "corporate practice." This phrase conceals faulty analysis in which, although the corporation's inability to act physically is recognized, the acts of its agents are attributed to it. The corporation is then treated as a human actor. Where the act is the practice of medicine, the corporation itself is said to practice and, being unlicensed, is held guilty of violating the licensure acts.[35] The flaw in this reasoning lies in its anthropomorphism. The law does not attribute the *acts* of a human being to that legal construct, the corporation. Instead, it imputes the *legal consequences* of such acts to the corporation. If a corporate agent's act is wrongful, its legal consequence—the liability prescribed for that wrong—will be imposed on the corporation, so far at least as the

[32] Nor is the classification the only possible one: a distinction may be based on the absence or presence of payment by the patient. The requirements placed on medical service will be strict where the patient pays full or partial compensation, the recipient of charity will have to take what is tendered to him.

[33] *Cf.* Texas and Pac. Coal Co. v. Connaughton, 20 Tex. Civ. App. 642, 50 S. W. 173 (1899); Owens v. Atl. Coast Lumber Corp., 108 S. C. 528, 94 S. E. 15 (1917).

[34] The suggested classification has significance beyond the formal field of corporate organizations. The types of "third interest" will recur with the same implications regardless of the organizational form. *Cf.* Ezell v. Ritholz, 188 S. C. 39, 198 S. E. 419 (1938) (partnership may not practice optometry). *Cf.* also PRINCIPLES OF MEDICAL ETHICS, *supra* note 2, c. 1, §2 (Groups and Clinics): "The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual doctors, each of whom, whether employer, employee or partner, is subject to the principles of ethics, herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession."

[35] *Cf.* Winslow v. Kansas State Bd. of Dental Examiners, 115 Kan. 450, 223 Pac. 308 (1924). "... that a corporation cannot stand up on its hind legs before a board of bar examiners and recite the rule in Shelley's case . . . is true, but meaningless. . . ." Weihofen, *"Practice of Law" by Non-pecuniary Corporations: a Social Utility* (1934) 2 UNIV. CHI. L. REV. 119, 129.

In an alternative analysis it would be admitted that those corporations where the position of the employed physician is relatively unimpaired, practice medicine but that they are not within the purview of the licensure statutes or enjoy a privilege to practice without license provided their employees are licensed.

sanction is susceptible of application to a corporation. If the agent's act is rightful, there is no liability consequent upon it to be imposed on the corporation. Instead, the act may create a right or privilege, the benefit of which may, by imputation, be enjoyed by the corporation.

Under this correct analysis, it will be seen that there is no occasion for the use of the term "corporate practice." The problem becomes instead whether the practitioner agents of a corporation furnishing medical services have engaged in unprofessional conduct by assuming obligations which weaken ethical restraints or result in improper delegations of responsibility to lay agents. This inquiry leads directly to an examination of the purposes and organization of the corporation subject to attack. If, as, for example, in most corporations of the first and second types, no conduct by professional and lay agents which is improper in this sense is found, then there will be no violation of the licensure acts to be imputed to the corporation. But where, as in most commercialized enterprises, the set-up threatens professional safeguards, violation of the licensure acts by the corporate agents may be found and imputed to the corporation.

In turning to the decisions which seem to have denied categorically to corporations the right to practice medicine,[36] an observation should be made. Most of the decided cases do not involve medicine proper, but relate to the practice of dentistry[37] and optometry[38] by corporations admittedly organized for profit, the third type in the classification. Is it surprising to find the courts applying a broad rule without nice distinctions, when they strike down these commercial ventures, especially where the corporate cloak hides quackery? Thus, a dentist changing his first names from Edgar Randolph to "Painless," and operating a complex network of "Painless Parker System" corporations, has furnished a much quoted cluster of precedents.[39] Decisions involving directly the right to practice medicine within a corporate framework are relatively rare. Yet here, too, most of the decided cases present a rather uniform pattern: profit organizations with the streak of quackery. Institutes for cancer treat-

[36] *Supra* note 29.

[37] Dentistry is distinguishable from medicine by its narrow field, rather uniform treatment, lesser seriousness of the "disease." These factors, and the relatively recent discovery by the public of the importance of dental care for health generally may account for belated admission of dentistry to the "professional sanctum." With a professional ethos less strongly developed, reported excursions into commercial fields are, accordingly, more frequent.

[38] The same distinction may be made for optometry, an occupation to which some courts deny professional character. Consultation of an optometrist may be viewed as a necessary preliminary or annex to a sales transaction. The commercial tinge is more pronounced and the reported cases revolve around a rather uniform fact situation: independent optometrists *versus* the department store employing a licensed optometrist or leasing a department to another optometrical entrepreneur maintaining chains of such leased departments.

[39] Parker v. Bd. of Dental Examiners, 291 Pac. 421 (Cal. App. 1930); Parker v. Bd. of Dental Examiners 1 P. (2d) 501 (Cal. App. 1931); Parker v. Bd. of Dental Examiners, 216 Cal. 285, 14 P. (2d) 67 (1932); People v. Painless Parker Dentist, 85 Colo. 304, 275 Pac. 928 (1929); People *ex rel.* Mahurin v. State Bd. of Dental Examiners, 85 Colo. 321, 275 Pac. 933 (1929); State Bd. of Dental Examiners v. Savelle, 90 Colo. 177, 8 P. (2d) 693 (1932); State Bd. of Dental Examiners v. Miller, 90 Colo. 193, 8 P. (2d) 699 (1932); see "Painless Parrmer, Inc." in Rust v. State Bd. of Dental Examiners, 216 Wis. 127, 256 N. W. 919 (1934).

ment with secret fluids and powders,[40] for liquor habits,[41] organizations where the treatment is part of a sales scheme for pharmaceutical products[42] are eliminated by judicial veto.

The second and first types of corporations present a different picture. The first is notably absent: no reported cases have been found where courts have directly prevented corporate practice by charitable or educational institutions, industry or railroads. On the contrary, occasional dicta evidence judicial tolerance.[43] The latest arrival in this group, the non-profit cooperative patient or "consumer" organizations, has received explicit judicial sanction so far in one case, recently decided in Washington, D. C.[44] No cases have been found directly[45] challenging the second group: corporations formed by physicians practicing in groups. This is not surprising as the policy arguments against them are less weighty. It may be assumed that they will acquire a similar "prescriptive right to exist" as has been accorded the various charitable and paternalistic organizations enumerated under the first group.

As the new forms of practice spread, the courts will have further occasion to reconsider the broad maxim condemning all corporations alike. It served satisfactorily in the past when it was exclusively invoked against anti-social activities, but its sweep becomes oppressive today as it threatens desirable experimentation. Until the legislatures have spoken explicitly, it is important that the courts exercise a nice discrimination in dealing with new forms of corporate organization in the medical field.

[40] State v. Baker, 212 Iowa 571, 235 N. W. 313 (1931); State v. Baker, 222 Iowa 903, 270 N. W. 359 (1936).

[41] Godfrey v. Medical Society of N. Y. County, 177 App. Div. 684, 164 N. Y. Supp. 846 (1917).

[42] People *ex rel.* Lederman v. Warden, 168 App. Div. 240, 152 N. Y. Supp. 977 (1915); State v. Heffernan, 28 R. I. 20, 65 Atl. 284 (1906).

[43] See People *ex rel.* State Bd. of Med. Examiners v. Pacific Health Corp., 12 Cal. (2d), 156, 157, 82 P. (2d) 429, 431 (1938); People v. John H. Woodbury Dermatological Institute, 192 N. Y. 454, 85 N. E. 697 (1908); Goldwater v. Citizens Casualty Co. of N. Y., 7 N. Y. Supp. (2d) 242, 248 (1938). Malpractice suits against industrial corporations or railroads have been denied by classifying the employed physician as an "independent contractor." The restriction of corporate liability to cases where the employing corporation acted negligently in selecting the physician is, in effect, a judicial encouragement of this form of practice. See Note, *Liability of Hospital for Injuries to Patients using Hospital Facilities* (1938) 48 YALE L. J. 81, 90; Metzger v. Western Ry., 30 F. (2d) 50 (C. C. A. 4th, 1929); Pearl v. West End Street Ry., 176 Mass. 177, 57 N. E. 339 (1900).

[44] Group Health Ass'n v. Moor, *supra* note 3.

[45] *Cf.* Iterman v. Baker, 15 N. E. (2d) 365 (Ind. 1938); Johnson v. Stumbo, 277 Ky. 301, 126 S. W. (2d) 165 (1938); Daly's Astoria Sanatorium v. Blair, 161 Misc. 716, 291 N. Y. Supp. 1006 (1936); Tarry v. Johnston, 114 Neb. 496, 208 N. W. 615 (1926). *Cf.* also State *ex inf.* Sager v. Lewin, 128 Mo. App. 149, 106 S. W. 581 (1907) for judicial toleration of a "Hernia Cure Co" under professional control; Chenoweth v. State Bd. of Medical Examiners, 57 Colo. 74, 141 Pac. 132 (1913).

# ENABLING LEGISLATION FOR NON-PROFIT HOSPITAL SERVICE PLANS

C. Rufus Rorem*

Hospital bills have always been hard to pay. Hospitalization is relatively more expensive than other health service, it is often unpredictable, it requires absence from gainful employment, and it is usually accompanied by other expenses for professional service. Consequently, the hospital bill is peculiarly an economic hazard of the type which might be removed by insurance.

*Economic Aspects of Hospital Service*

The public attitude toward the costs of health service, particularly hospitalization, differs from the attitude toward loss of property or income. For centuries, society has held the position that a person is entitled to necessary health service regardless of his ability to pay. Before the days of hospitals and medical specialties, a rough-and-ready justice was obtained by the family physician, who charged his patients according to their real or presumed "ability to pay." With the development of specialized services and equipment for diagnosis and treatment, the personal benevolence of the family doctor was supplemented by the impersonal procedures of government taxation and organized philanthropy.

Hospital care has never been considered a private commodity, to be withheld from persons unable to pay. More than 70% of the million hospital beds in America are in government hospitals, and 25% more are in non-profit hospitals built through charitable contributions. In any one year, about 30% of the patients hospitalized for acute illnesses receive care free of cost to themselves, and another 20% pay less than the regular charges for hospital care. The ratios of free service are higher in the larger cities.

Since hospital care is not a private commodity, it has been difficult to interest the general public in private insurance against hospital bills. Hospitalization is a type of social service; hence hospitalization insurance has been regarded as basically a form of social insurance.

The average man knows that he is entitled to receive the necessary care regardless of his ability to pay at the time of sickness. But many employed persons of limited means dislike the "means test" for free or part-pay hospitalization, and have made

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valiant attempts to purchase the care as private patients from their own resources. Such persons have welcomed a contributory plan by which, through equal and regular periodic payments, they may budget their hospital service along with other necessities. Likewise, hospital administrators and trustees have accepted this method of helping to regularize hospital income.

*Origins of Hospital Service Plans*

Ten years ago a hospital service plan was established by Baylor University Hospital in Dallas, Texas, an experiment with 1500 school teachers which began a movement that has grown to 56 city-wide and state-wide plans approved by the American Hospital Association, with 5,000,000 members. The success of the Baylor experiment derived from the fact that the hospital provided services rather than cash indemnities to the subscribers. Many of these subscribers might have received service free or at a discount. In any event, the $6 annual subscriptions provided sufficient money to reimburse the hospital adequately for all care to the patients among the subscribers to the insurance plan.

Apparently the department of insurance of Texas did not consider that Baylor Hospital was engaged in the "insurance" business, but looked upon the procedure as a group contract for the sale of services by the hospital to the subscribing members. Similar one-hospital plans were initiated with reasonable success in New Orleans, Fort Worth, Memphis, and other cities. The resulting competition among hospitals and the desire of many subscribers to choose their hospital at time of illness rather than at time of enrollment, led to consideration of free-choice hospital service plans. Such plans were soon in operation at various places in the country. During 1932 and 1933, free-choice plans were begun in Sacramento, California, Bluefield and Charleston, West Virginia, Newark, New Jersey, and St. Paul, Minnesota. Steps had been taken for similar plans in New Orleans, New York City, Cleveland, and Washington, D. C. Several of these new plans instituted plans for dependent coverage at family rates, ranging from $1 to $2 per family, depending on type and degree of protection.

*The New York State Enabling Act*

A number of state departments of insurance had ruled that hospital service contracts, even if issued by one hospital, were a form of insurance and that hospital service policies could be issued only by stock and mutual insurance companies which met the established requirements as to capital stock, reserves, and assessments. The issue came to a head in New York and in Ohio during 1933. The United Hospital Fund of New York wished to form a hospital service association which would contract for the provision of service in metropolitan hospitals to groups of persons making regular subscriptions to the association. The Cleveland Hospital Council had similar plans under way.

The New York state superintendent of insurance advised that such a function, although desirable, could be performed only by a stock or mutual insurance company.

New York civic leaders, hospital administrators and trustees, and physicians cooperated in drafting and sponsoring an enabling act, which became a law May 16, 1934.[1] This New York law was the first of a series of 24 enabling acts which have been passed to permit the establishment of non-profit hospital service corporations. Because its provisions were soon incorporated, in whole or in part, in other state legislation, they may be summarized briefly at this point.

The first section (§452), "Definition and Scope of Article," stated that "any corporation heretofore or hereafter organized under the membership corporation laws of the State of New York for the purpose of establishing, maintaining and operating a non-profit hospital service plan . . . shall be governed by this article and shall be exempt from all other provisions of the insurance law of this state, unless specifically designated herein. . . ." A non-profit hospital service plan was defined as a plan "whereby hospital care may be provided by the said corporation or by a hospital with which it has a contract for such care . . . to such of the public who become subscribers to said plan under a contract which entitles each subscriber to certain hospital care." There was no restriction on the number or type of contracting hospitals, except that they must be "maintained by the state or any of its political subdivisions, or maintained by a corporation organized for hospital purposes under the laws of this state, or such other hospitals as shall be designated by the state department of social welfare."

The next section (§453), "Incorporation," stated that each certificate of incorporation must be approved and filed in accord with the membership corporations law, and carry written evidence of the "consent of the superintendent of insurance of the State of New York and the state department of social welfare." There was a provision that "at least a *majority* of the directors of such corporation *must be* at all times *directors or trustees of hospitals* . . . which have contracted or may contract with such corporation to render to its subscribers hospital service." (Italics added.)

Section 454, "Contracts," limited the corporation to entering into contracts with hospitals of the type described in Section 452, and referred to rates charged to subscribers and paid to hospitals. "(2) *The rates charged* by such corporation to the subscribers for hospital care shall at all times be subject to the approval of the superintendent of insurance. . . . (3) All *rates of payments to hospitals* . . . shall be approved prior to payment by the state department of social welfare." (Italics added.)

The next four sections contained brief general statements for the regulation of the business and finances of the hospital service plans. Section 455 provided for annual reports to be filed with the superintendent of insurance "which shall be in such form and shall contain such matters as the superintendent shall prescribe." Section 456 covered examinations, and gave the superintendent of insurance powers to visit and examine the books, papers, and documents, which were similar to those exercised over stock and mutual insurance companies. Acquisition costs were made "subject

[1] N. Y. Laws 1934, c. 595, adding Article 14, §§452-461, to the New York Insurance Law. The 1939 legislature adopted a new codification of the Insurance Law, effective June 15, 1939, in which Article IX–C, §§250-259, was substituted for Article 14, broadened to include non-profit medical indemnity corporations, and amended in other respects.

to the approval of the superintendent of insurance" by Section 457, and funds were required by Section 458 to be "invested only in securities permitted by the law of this state for the investment of assets of life insurance companies."

Section 459 provided that disputes between the corporation and contracting hospitals "may be submitted to the department of social welfare for its decisions..." and the decisions of the superintendent of insurance or the department of social welfare were made subject to revision "by proper proceedings in a court of competent jurisdiction." Section 460 stated that any dissolution or liquidation "shall be under the supervision of the superintendent of insurance," with all powers granted in respect to insurance corporations generally.

Every corporation operating a non-profit hospital service plan and subject to the above provisions of the insurance law was declared by Section 461 "to be a *charitable and benevolent institution,* and all of its funds shall be *exempt from* every state, county, district, municipal and school *tax,* other than taxes on real estate and office equipment."[2] (Italics added.)

On the basis of this law, Associated Hospital Service of New York began operations May 1, 1935, followed by the Rochester Hospital Service Corporation in June, 1935. Other plans were soon organized in Albany, Buffalo, Geneva, Jamestown, Syracuse, Utica and Watertown. These nine plans now serve the entire state and, on July 1, 1939, had a total membership of 2,000,000 persons.

### *Enabling Acts in Other States*

Following the lead of New York, 23 additional states (and Manitoba) have passed special enabling acts for non-profit hospital service plans, bringing them under the departments of insurance and in some instances also the departments of health or welfare. The dates of passage[3] for all enabling acts[4] were as follows: 1934—New York; 1935—Alabama, California, Illinois; 1936—Mississippi;[5] 1937—Georgia, Maryland, Massachusetts, Pennsylvania; 1938—Kentucky, New Jersey; 1939—Connecticut,

[2] One brief section amended the membership corporation law by requiring the secretary of state to obtain consent from the departments of insurance and welfare before filing a certificate of incorporation for any service plan. The final section declared that "this act shall take effect immediately."

[3] The Iowa, Michigan, and Wisconsin acts were passed in 1939 after bills had been defeated in 1937.

[4] *New York: supra* note 1; *Alabama:* Acts 1935, act no. 544, am'd, Acts 1936 (Ext. Sess.) act no. 169, Acts, 1939; *California:* Stat. 1935, c. 386, am'd, Stat. 1937, c. 881, Stat. 1939, A. B. 1712; *Illinois:* REV. STAT. (1937) §§551-562; *Mississippi:* Laws 1936, c. 177; *Georgia:* Laws 1937, no. 379, p. 690; *Maryland:* Laws 1937, c. 224; *Massachusetts:* ANN. LAWS (1938 Supp.) c. 176A; *Pennsylvania:* STAT. ANN. (Purdon, 1938) tit. 15, c. 49A, §§2851-1301—2851-1309; *Kentucky:* Acts 1938, c. 23; *New Jersey:* Laws 1938, c. 366; *Connecticut:* Laws 1939, S. B. 51; *District of Columbia:* S. B. 497, 76th Cong. 1st Sess. (1939); *Iowa:* Laws 1939, c. 222; *Maine:* Laws 1939, c. 149; *Michigan:* Laws 1939, H. B. 145; *New Hampshire:* Laws 1939, H. B. 232; *New Mexico:* Laws 1939, c. 66; *Ohio:* Laws 1939, S. B. 181; *Rhode Island:* Laws 1939, c. 719; *South Carolina:* Acts 1939, H. B. 845; *Texas:* Laws 1939, Subst. H. B. 191; *Vermont:* Laws 1939; *Wisconsin:* Laws 1939, S. B. 288.

In subsequent references to enabling acts cited in this note these statutory citations will not be repeated.

[5] The Mississippi act, *supra* note 4, does not require plans to be non-profit corporations. It provides "for the organization and regulation of hospital service associations," organized as capital stock corporations with a minimum of $10,000 paid-in capital. The law was sponsored by the state medical and hospital associations.

District of Columbia, Iowa, Maine, Michigan, New Hampshire, New Mexico, Ohio, Rhode Island, South Carolina, Texas, Vermont, Wisconsin.

The 24 states have a total population of 88,000,000, based upon the 1935 census estimates. Not all of them have hospital service plans in operation under the enabling acts. Those without active plans in September, 1939, were Iowa, New Hampshire, New Mexico, South Carolina, Texas, Vermont, and Wisconsin.

Nine other states have ruled, through their attorneys general or departments of insurance, that non-profit hospital service plans are not "insurance" and have permitted them to operate under the general corporation laws, exempt from the regulations covering stock and mutual insurance companies. These states are: Colorado, Delaware, Louisiana, Minnesota, Missouri, North Carolina, Tennessee, Virginia, West Virginia. The executives and trustees of service plans in Minnesota, Tennessee, and West Virginia initiated legislation in 1939 to give them insurance department supervision, but in each case the bill was lost in committee or upon vote of the legislature.

The other 16 states of the union presumably require that hospitalization insurance may be supplied only through stock and mutual insurance companies, regardless of whether benefits are supplied as cash indemnity or hospital service.

*Origins of Hospital Agency Contracts*

Late in 1933, when enabling legislation was under consideration in New York, the insurance commissioner of Minnesota required the St. Paul Hospital Service Association to rewrite the contracts with hospitals in such a way as to make the association the agency for the member hospitals.[6]

Early in the year 1934, the Hospital Council of Cleveland was completing the administrative details for a hospital service plan under the non-profit laws of Ohio. Attorneys for the Council proposed to establish the hospital service association as the agent of the hospitals, severally and jointly, and argued that such an arrangement would remove the activities from the field of insurance according to the laws of Ohio. Before the merits of the case could be tested, there was discovered in the General Code, Section 669, passed in 1903, a statement which specifically authorized the proposal being made.[7]

This act, adopted thirty years previously, did not permit the associations to offer contracts to non-residents of the county in which the association and hospitals were located. But it sufficed to authorize establishment of the Cleveland Hospital Service

[6] Stated in depositions submitted in evidence in Currie and Schlief v. Minnesota Hospital Service Ass'n, a case now pending in District Court, Ramsay County, Minnesota.

[7] OHIO GEN. CODE (Page, 1937) §669, prior to amendment in 1939, reads as follows: "*No law* of this state *pertaining to insurance shall be construed to apply to the establishment and maintenance* by individuals, associations or corporations *of sanitariums or hospitals* for the reception and care of patients, for the medical, surgical or hygienic treatment of any and all diseases, or for the instruction of nurses in the care and treatment of diseases and in hygiene, or for any and all purposes, *nor to the furnishing of any or all such service*, care or instructions in or in connection with any such institution, *under or by virtue of any contracts made for such purposes, with residents of the county in which such sanitarium or hospital is located.*" (Italics added.)

Association in July, 1934, and later plans in Akron, Toledo, Youngstown, Canton, Newark, Columbus and Portsmouth. An amendment to Section 669 was passed in 1939 which brought non-profit hospital service plans within the supervision of the department of insurance and removed the county-line limitation.

*Hospital Responsibility Under Enabling Acts*

When the Cleveland Hospital Service Association was launched in 1934, the "inter-hospital agency contract" established the hospitals as the principals in the contractual obligations for expenses of the plan and services to the subscribers. The hospitals agreed to accept flat rates per day for services to subscribers, or such *pro rata* payments as the available funds permitted. In addition, they agreed to fulfil all contracts until the end of the contract year, and, if necessary, to refund payments to the association to cover necessary operating expenses. This principle of hospital responsibility was expressly recognized in several enabling acts, the first being that passed by the Maryland Legislature in 1937, which read as follows: "Each contract executed . . . by the applicant with any hospital for the furnishing of service to the subscribers to the hospital service plan obligates . . . each hospital party thereto to render the service to which each subscriber may be entitled."

During the year 1939, similar provisions appeared in the enabling acts of Maine, Michigan, Ohio, and South Carolina. Other state insurance departments have required that hospital contracts be drawn in such manner as to relieve the subscriber from the possibility of assessment or failure to receive care in case of any temporary or long run difficulties of the corporation to pay the agreed rates to hospitals or other expenses.

*Need for Administrative Regulation*

The original New York enabling act gave wide discretionary powers to the state Superintendent of Insurance and the State Department of Social Welfare. The California and Illinois laws passed in 1935 followed almost identically the wording of the New York bill. As a guide to the New York plans, the Department of Insurance issued a letter, during the summer of 1937, with suggestions intended to protect the interests of the subscribers and the associations.[8] These included, among other suggestions: freedom of subscriber from the requirement of paying his complete annual dues at time of illness, equal payments to non-member hospitals in emergency cases, non-cancellable policies within a year. The Department of Social Welfare also indicated certain general policies as the basis of approval of the certificate of incorporation. These included: evidence of need as indicated by the general population and the number of other associations, the character and standing of the incorporators, adequacy of working capital at time of organization.

As new enabling acts were passed from 1937 to 1939, they carried more specific

[8] Cited by Carl Metzger of Buffalo in paper on "Laws Governing Group Hospitalization in New York State." Mr. Metzger's paper and similar papers by Ray F. McCarthy of St. Louis and J. Philo Nelson of Oakland, California, mentioned the development of regulations in the various states. The papers were printed by the American Hospital Association as *Special Meeting of Group Hospital Service Plan Executives*, Atlantic City, N. J., Sept., 1937.

provisions and defined the rights and powers of the state regulatory bodies as well as the obligations of the plans as to form of organization, public policy, accounting and administrative procedures, hospital responsibility, financial solvency, investments, etc. The Commission on Hospital Service and Council on Hospital Service Plans of the American Hospital Association attempted to place the best features of these regulations into a model enabling act which was prepared for distribution in 1938, and which influenced the legislation in several states during the 1939 sessions. This complete "model bill" appears as Appendix A to this article. There were some desirable standards for the administration of a successful non-profit hospital service plan which did not seem appropriate for inclusion in the laws of the various states. Many of these appear in the *Standards for Non-Profit Hospital Service Plans* used as the basis for approval by the Commission on Hospital Service. The complete standards appear as Appendix B to this article.

Certain features tend to be characteristic of all the enabling legislation. Other special phases differentiate some of the bills from all others. An attempt will be made to summarize the most important of the common features, as well as some of the unique aspects of the various enabling acts.

*Hospital Service Plans as Insurance*

Most of the enabling acts open with a statement that hospital service corporations are "exempt from all provisions of the insurance code of this state not otherwise specifically designated therein." This was the original wording of the New York act, and was followed in a number of states, for example, Iowa, Illinois, Kentucky. The Pennsylvania Act states that such corporations "shall be subject to regulation by the Department of Insurance as provided in this Act." The same result is obtained with different wording in the laws of Georgia and Texas, each of which states that "hospital service corporations shall be governed by this act, and shall not be construed as being engaged in the business of insurance under the laws of this state."

From the economic point of view, hospital service plans are a form of insurance. From the provisions of the various state regulations and the enabling acts, it appears that they constitute a special type of insurance differing from the stock and mutual companies.

*Exemption from Taxation*

The original New York law provided that the hospital service plans were to be exempt from "every state, county, district, municipal and school tax, other than taxes on real estate and office equipment." This general formula was followed elsewhere, notably District of Columbia, Illinois, Maryland, New Jersey and California. When the New York Enabling Act was amended in 1939 as Chapter 28, Article IX-C, of the Consolidated Laws, the tax exemption was extended to "every state, county, district, municipal and school tax." The same general rule is applied in the states of Alabama, Connecticut, Georgia, Iowa, Massachusetts, Maine, Michigan, New Mexico, Ohio, Pennsylvania, Rhode Island, South Carolina, Texas, Wisconsin.

Non-profit hospital service associations have been ruled *exempt* from federal income taxation, provided they meet the requirements of an "organization for social welfare," as described in Section 101(8) of the Revenue Act of 1936. Rulings by the Bureau of Internal Revenue have been made with regard to a number of the hospital service plans. Directors or trustees of each plan have followed the advice of legal counsel and submitted the required evidence for consideration by the income tax unit. But non-profit hospital service associations have been ruled *not exempt* from liability for social security tax provisions. They are not classified as "charitable organizations" under Title IX, Section 907(c), of the Social Security Act, and executives are required to file returns and make contributions on the same bases as other corporations. In states where enabling acts have not been passed, the various non-profit plans have been exempt from capital stock and corporate taxes not assessed against other charitable and benevolent institutions.

*Investment of Funds*

Practically all of the enabling acts require that the funds of the corporation shall be invested only in securities permitted by laws of the state for the investment of the assets of "life insurance companies." This was the original New York regulation and was continued in the 1939 amendment. Other states which have this restriction are Illinois, Iowa, Kentucky, New Jersey, Maryland, Michigan, New Mexico, Ohio, Pennsylvania, and South Carolina. The New England states register a departure from this regulation, with Maine, New Hampshire, and Vermont restricting the assets in accord with those recognized as legal investments for "savings banks." Massachusetts restricts investments to those for "insurance companies," and Connecticut applies the same restrictions as for "trust funds," excepting real estate mortgages.

*Composition of Board of Directors or Trustees*

The original New York law required that a majority of the board of directors or trustees must be representatives of hospitals with which the corporation had contracts for service to subscribers. This feature was removed in the 1939 amendment of the New York law, but appears in various modifications in a number of the other enabling acts passed during the past five years. The following states include in their enabling acts a requirement that "at least a majority" of the directors of the corporation must be administrators, trustees, or members of the clinical staffs or advisory boards of the member hospitals: Georgia, Iowa, New Jersey, Maine, Ohio, Rhode Island, and Texas. The Illinois law requires the majority of the board to be hospital representatives *and* medical or dental practitioners. In California, two thirds of the board of directors must be composed equally of representatives of contracting hospitals and qualified practicing physicians in the state of California.

The new enabling acts for Michigan and South Carolina call for representation from the general public, the hospitals, and the medical profession. The law for the District of Columbia requires that one third of the trustees shall be appointed by the

Commission of the District of Columbia, one third by the Medical Society, and one third by a group representing the hospitals.

A special feature of the Iowa requirement is that the board of directors shall consist of at least nine members, not more than one being from any one hospital. This means, of course, that no plan can be placed in operation until nine hospitals are enrolled as member institutions. A somewhat different guaranty that the plans will serve relatively large communities is derived from the Wisconsin requirement that the member hospitals must be not less than six, and have a total bed capacity of not less than 600.

*Eligibility of Hospitals*

The typical requirement for eligibility for a hospital to serve as a contracting institution is "approval" by some state regulatory body, usually the state department of health or social welfare, although in some states, such as Maryland, the insurance departments exercise the full authority. In Connecticut the Medical and Homeopathic Examining Boards submit the list of approved hospitals. Most of the plans state explicitly that contracts may be entered into with hospitals maintained "by the state or any political subdivision, or maintained by a corporation organized for hospital purposes under the laws of this state, or other hospitals approved by the state department of welfare."

The Kentucky law makes no provision for unincorporated hospitals. The Ohio law is limited exclusively to non-profit institutions, and proprietary institutions are not eligible for participation. The South Carolina law requires contracting hospitals to hold membership in the South Carolina Hospital Association. The 1939 revision of the New York law permits hospitalization contracts with "hospital service plans and hospitals of other states, subject to the supervision of other states." In Alabama, member hospitals must have the approval of the Alabama Hospital Association and the State Board of Censors of the Alabama Medical Association. In Georgia, a member hospital must be recommended by "the State Board of Health or the Medical Association of Georgia, or the Georgia Hospital Association, or the County Medical Society."

The Ohio law states explicitly that services may be provided in other than member hospitals in case of emergency. The Georgia and Texas acts assume that benefits may be provided in non-member hospitals, requiring that the certificates state "the rate per day or week payable by said corporation for hospital services rendered to said member at any hospital other than the hospitals with which said corporation shall have contracted."

*Rates to Subscribers and to Hospitals*

All of the enabling acts require that the rates charged to subscribers be subject to approval by the state departments of insurance. A number of the acts (New York, New Jersey, Connecticut) state that such subscription rates may be refused approval

by the insurance commissioner if he finds them "excessive, inadequate, or unfairly discriminatory."

The rates of payments to the hospitals are, in some instances, subject to approval by some agency other than the department of insurance, such as the Departments of Social Welfare in New York and Illinois, and the Department of Institutions and Agencies in New Jersey. A provision of the revised 1939 act in New York carries the following statement with regard to rates paid to hospitals: they must be "approved as to *adequacy* by the commissioner of social welfare and as to *reasonableness* by the superintendent of insurance."

*Examinations and Reports*

Each of the various acts contains a requirement relating to the examination of the assets, liabilities, and methods of conducting business, and all other affairs of the corporation. These matters may be investigated whenever the insurance departments of the states deem it expedient, and the expenses of such examination must be borne by the corporation. New Mexico requires that not more than $10.00 per day, or a maximum of $100, plus expenses, may be charged for each examination. Rhode Island raises the maximum to $200.

All of the enabling acts require that reports shall be made annually in such form as the Departments of Insurance "shall prescribe."

*Working Capital, Reserves, and Surplus*

The more recently enacted enabling acts make definite recommendations as to the amount of working capital, reserves, and surplus which must be maintained by non-profit hospital service corporations. Some also place restrictions on the proportions of the earned income which may be used for administrative or overhead expenses.

The 1937 Maryland act carries the statement that the amount of money actually received for working capital must be sufficient to carry all acquisition costs and operating expenses "for a period of at least three months from date of issuance of the certificate." The Michigan law, passed two years later, states that the amount must be sufficient for a "reasonable length of time from the date of the issuance of the certificate of authority, and is not less than the sum of $10,000." Maine sets a minimum requirement of $5,000. Under the Ohio law, the corporation must have a cash surplus of at least $1,000 at the time of beginning operations.

The Michigan and Maryland laws both prescribe "that the amounts contributed as working capital of the corporation are repayable only out of earned income over and above operating expenses and hospital services," as well as the reserves necessary to insure maturity of the contracts. The Alabama law requires that bonds be placed on deposit with the Insurance Commissioner, with a minimum of $3,000 and a maximum of $20,000, based upon the annual earned income.

The New Jersey and the recently amended New York laws stipulate that each corporation must maintain a special "contingent surplus" over and above reserves

and liabilities. This surplus must be accumulated at the rate of 2% annually of the net premium income after the first year for a period of four years. The New York statutes change the rate of 2½% after this period, until a maximum of $100,000 is reached; however, if the net premium income for the previous five years was less than $1,000,000, a contingent surplus of 55% of the average annual premium may be maintained.

A number of states have now established maximum amounts which may be used for acquisition and administration expenses. The California law limits the amount to 25% of the earned income. The Texas act restricts the amount of the administrative expenses to 15% of the dues, subject to the authorization or approval of the Board of Insurance Commissioners. The New Jersey and New York laws set a maximum of 20% for administrative expenses not including expenses directly connected with the furnishing of benefits during each year of operation, and maximums of 20%, 15%, and 10% for solicitation during the first, second, and third years, respectively.

By implication, each of the laws declares a plan to be "insolvent" and subject to liquidation or rehabilitation if unable to fulfil outstanding contracts and liabilities and to maintain the reserves required by law. A question arises as to whether or not contracts are adequately fulfilled when arrangements are made for reductions of rates in the payments to hospitals. Apparently an adjustment of rates with hospitals fulfils the legal obligation from the standpoint of the insurance departments, and restores the financial position of the plan, even though the reduced payments may never be completely recovered by the hospitals.

*Limitations On Hospital Service*

Most of the enabling acts state that hospital care is to be provided through the hospitals with which contracts have been drawn. Several of the enabling acts indicate that medical service shall not be included. The Michigan bill states that hospital service "shall be limited to hospital care such as bed, board, use of operating room, ordinary medications, surgical dressings, and general nursing care. Nothing in this act shall be construed as to permit a hospital or other corporation to engage in the practice of medicine in violation of Act 237 of the Public Acts of 1899 . . . or to contract to furnish the services of a physician for subscriber."

The Alabama act reads as follows: "the service therein provided shall not include any medical or surgical services." The Georgia and Texas laws carry identical statements: "The corporation shall not contract to furnish to the member a physician or any medical service, nor shall corporations contract to practice medicine in any manner." The Wisconsin act states that the contract "shall provide for hospital services only, and shall not embrace medical services." The California statute prescribes that medical services may be included in the benefits, in the following statements: "Hospital services may include . . . indemnification of the beneficiary or subscriber for the cost and expense of professional medical service rendered during hospitalization."

By and large, the terms "hospital service," "hospital care," and "hospitalization" are interpreted to mean those services ordinarily rendered by the contracting hospitals. This question came to a legal test in Pennsylvania during the summer of 1938, when the County Medical Society objected to the issuance of a charter to Associated Hospital Service of Philadelphia by the Court of Common Pleas, under the enabling act for hospital service plans. The County Medical Society maintained that the provision of certain medical services in the hospital service plan benefits (X-ray, laboratory, anesthesia, basal metabolism tests, electrocardiograms, and physiotherapy) exceeded the intent of the enabling act, which was to provide "hospitalization" and constituted the illegal practice of medicine by the hospitals, in contravention of statute.[9] The issue of compliance with the enabling act in the application for charter was placed before a Special Master for report to the County Court.

Evidence was submitted to show that the provision of medical services by hospitals to subscribers of hospital service plans was consistent with the existing practice of providing such services to the private patients of the contracting hospitals. Attorneys for the service plan did not argue that the services mentioned were *not* medical services, but merely that the law contemplated permission to furnish these services when "a part of" hospitalization. The issue of the illegal practice of medicine by the hospitals was placed before a Special Master for report to the County Court. Before the evidence was completed, the County Medical Society withdrew the objections to the charter, upon the agreement that the Charter would refer to these services as "incident to" rather than "a part of" hospitalization.

In discussing the merits of the case, the Master said: "It is apparent that the hospital does not agree to perform any of these services, but merely to furnish facilities whereby they may be performed for the benefit of the patient; and no change is made, or contemplated, by the amended plan which will in any way alter the present relationship between the hospital, the patient and the doctor performing the services." In another place he said: "In the opinion of the Master, there is no agreement on the part of any one to 'practice medicine.' It is indemnification to the patient for at least a part of the costs of these services, and nothing more."[10]

*Hospital Responsibility*

Mention has been previously made of the requirement in certain enabling acts that a direct obligation be assumed by the hospitals with which the hospital service corporation has contracted. Originally the agency contracts in New York were drawn in such manner as to make the hospital contract and the subscriber contract cancellable on short notice—in the case of the New York City plan, thirty days. Upon recommendation of the Departments of Insurance, a number of the plans changed their contracts so that the hospitals and the plan assumed their obligations for a twelve-month period. Conversely, the corporation was not permitted to promise

[9] PA. STAT. ANN. (Purdon, 1938) tit. 63, c. 10, §401.

[10] Master's Report, *In re* Application for Charter of the Associated Hospital Service of Philadelphia, Common Pleas No. 7, March Term, 1938, No. 3470.

benefits more than twelve months in advance. These features were later included in the New Jersey and New York acts, with the statement that contracts may be written with the provision that they would be renewed from year to year unless there was one month's prior written notice of termination given by either the subscriber or the corporation.

The Connecticut, New York and New Jersey laws provide that no contract shall entitle more than one person to services, except a family contract "to a husband and wife, or husband, wife and their child or children not over eighteen years of age." Family contracts are, of course, regularly issued in most of the states, but these revised laws bring them exclusively within the province of the enabling acts.

*Special Provisions*

A number of special provisions are of sufficient interest to mention, although they do not appear in the enabling acts of a large number of states. A few will be cited. The acts do not affect the liability of an employer under the provisions of the Workmen's Compensation Law. This is specifically mentioned in Connectitut, New York, New Hampshire, and Vermont. The Connecticut, New York and New Hampshire laws state that fraternal benefit societies are not affected by the acts. New Hampshire forbids a hospital service corporation from any other state or country to be licensed in New Hampshire. The New Jersey and New York laws both permit local plans to operate in other states. The Connecticut law provides that plans "may merge." The Alabama act requires that a hospital service corporation pay the same amount to a hospital outside of Alabama as to one within the state. The Wisconsin enabling act carries a unique statement of public policy as a preamble to the provisions of the administration of the law.[11]

The New York law permits the Insurance Commissioner to refuse a charter if he considers the incorporation "contrary to the interest of the people." The Rhode Island Commissioner is to base his decision on "public convenience and advantage." The Ohio Superintendent of Insurance must be satisfied that the proposed plan is "established upon sound actuarial and financial bases, in view of the experience of non-profit hospital service plans already in existence."

The Rhode Island law does not permit the solicitation of subscribers on a commission basis, or any basis where the compensation is conditioned upon enrollment of subscribers, unless the method of solicitation and rate of compensation shall have received written approval by the Chief of the Division of Banking and Insurance.

[11] Wis. Laws 1939, S. B. 288, §1: *Public Policy:* As a guide to the interpretation and application of this section, the public policy of this state is declared to be: to ease the burden of payment for hospital services, particularly in the low income groups, where with the advance of scientific methods the payment for adequate hospital services is a pressing problem with grave social ramifications, non-profit hospital service corporations, based on the tested experience in many parts of the United States, economically sound, socially beneficent, are needed.

While in no way changing the present status of voluntary hospitals in the state, these corporations will enable a larger number to procure for themselves adequate hospital services and leave the use of the free and part free services given by the hospitals to those whose economic status makes self-procurement of such services impossible. Without imposing the burden on the public treasury and free from any motive of profit, these corporations will contribute to the solution of a pressing social and economic problem in the state and merit the support of the citizens.

The New Hampshire law requires that "all benefits are payable to the hospital." The Texas law states that corporations shall not pay any funds collected from subscribers to any hospital "until after care has actually been rendered."

A special provision in Michigan permits the corporation to "receive and accept a lump sum or per capita sum from governmental or private agencies," associations or groups in payment of subscriptions of persons or groups of persons in need of hospital care who cannot pay the cost of the subscription.

In Ohio, each plan must pay a fee of $250 at time of formation, and an annual fee equal to one mill for each contract issued and outstanding as of the 1st of March each year. In Texas, no compensation may be paid "in excess of $6,000 per year" to any employee, and all salaries are to be approved by the board of Commissioners. In Massachusetts, all salaries of $5,000 or more must be approved by the board of directors of the plan.

The enabling act of Vermont makes the act apply not only to hospital service plans, but also to those furnishing hospital, medical, surgical, or nursing service. The New York law as amended in 1939 applies to "non-profit medical indemnity corporations." Group Hospitalization, Inc., of the District of Columbia is authorized to "cooperate, consolidate, or contract" with groups or organizations interested in promoting and safeguarding the public health. The Texas law makes specific provisions that "officers or directors may be allowed reasonable and necessary expenses" for five meetings of the corporation per year. A number of the acts require that all persons who solicit, receive, or procure applications must be "licensed" by the Superintendent of Insurance of the state under which the plan is chartered.

*The Commission On Hospital Service*

The Commission on Hospital Service of the American Hospital Association was formed in 1937 for the study and development of hospital care insurance and related problems of hospital finance. It is financed separately from the general activities of the American Hospital Association, in part by a grant from a philanthropic foundation and in part from contributions by plans toward a Research Program of the Council on Hospital Service Plans, organized within the Association.

The Commission issues approval certificates for non-profit hospital service plans which meet certain standards. In states where special enabling acts have been passed, hospital service plans must be organized under such laws. The Commission neither approves nor disapproves stock or mutual insurance companies, and exercises no legal control over the hospital service plans. The approval program is a supplement to, rather than a substitute for, the regulation of hospital service plans by state insurance bodies. The primary features of the standards for approval are (1) the clear establishment of the responsibility of member hospitals for services to subscribers and (2) financial status and operations which adequately protect the interests of subscribers and member hospitals.

The hospital responsibility requirement is not accidental; it is fundamental. Without such a guaranty, the plans would be less able to protect the interests of sub-

scribers than a well-managed stock or mutual insurance company. In exchange for the hospital guaranty, the management of a plan owes it to member hospitals to conduct the affairs in such manner as to avoid the necessity of calling upon the guarantors. Suggestions for efficient administration are contained in the Standards adopted by the Commission as the basis for approval. These include non-profit organization, hospital responsibility, community representation, freedom of choice, adequate working capital, appropriate rates and benefits, accounting and statistical control, sound administrative procedures, and harmonious staff and hospital relationships.

Hospital service plans are not a panacea for the hospital or the public. Most of them have been established for semi-private rather than ward service plans, and they do not include the services of attending physicians and surgeons. The hospital service plans may be looked to as a guide in shaping a wise and administratively efficient national health program. The future of the voluntary hospitals is dependent upon the future of voluntary hospital care insurance. The service plans are an American approach to the problem of the uncertainty of sickness costs; they combine the advantages of individual initiative and social responsibility.

## APPENDIX A

### PROPOSED MODEL LAW TO ENABLE THE FORMATION OF NON-PROFIT HOSPITAL SERVICE ASSOCIATIONS UNDER THE SUPERVISION OF THE VARIOUS STATE DEPARTMENTS OF INSURANCE

Prepared by the Commission on Hospital Service and the Council on Hospital Service Plans of the American Hospital Association, January, 1939

I. *Scope:* Any corporation organized not for profit under the General Corporation Act of the State of ..... for the purpose of establishing, maintaining and operating a non-profit hospital service corporation, whereby hospital service may be provided by a hospital or group of hospitals with which such corporation has a contract for such purpose, to such of the public as become subscribers to said corporation under a contract which entitles each subscriber to certain hospital care, shall be governed by this act and shall be exempt from all other provisions of the insurance laws of this state, unless otherwise specifically provided herein.

II. *Incorporation:* The articles of incorporation of every such corporation, and amendments thereto, shall be submitted to the Department of Insurance, whose approval thereof shall be endorsed thereon before the same are filed with the Secretary of State; provided, however, that if the articles of incorporation of any such corporation shall have been filed with the Secretary of State prior to the effective date of this statute, the approval thereof by the Department of Insurance shall be evidenced by a separate instrument in writing filed with the Secretary of State.

III. *Directors:* The Directors of such corporation must at all times be composed of the following groups in such proportions as to give equitable representation: (1) administrators or trustees of hospitals which have contracted with such corporation to render hospital service to the subscribers; (2) licensed physicians, exclusive of group (1); (3) general public exclusive of groups (1) and (2).

IV. *Contracts:* Such corporation may enter into contracts for the rendering of hospital service to the subscribers only with hospitals approved by the Department of Insurance or Departments of Health or Welfare. All contracts issued by such corporation to the subscriber shall constitute direct obligations of the hospital or hospitals with which such corporation has contracted for hospital service.

V. *Rates:* The rates charged to the subscribers for hospital service and the rates of payment by such corporation to the contracting hospitals, at all times shall be subject to the approval of the Department of Insurance.

VI. *Application for Certificate:* A corporation subject to the provision of this act may issue contracts only when the Department of Insurance has by formal certificate or license authorized it to do so. Application for such certificate of authority or license shall be made on forms to be supplied by the Department of Insurance, containing such information as it shall deem necessary. Each application for such certificate or license shall be accompanied by copies of the following documents: (a) certificate of incorporation; (b) by-laws; (c) proposed contracts between the corporation and participating hospitals showing terms under which hospital service is to be furnished to subscribers; (d) contracts to be issued to subscribers showing a table

of the rates to be charged and the benefits to which they are entitled; (e) financial statement of the corporation, including the amounts of contribution paid or agreed to be paid to the corporation for working capital and the name or names of each contributor and the terms of each contribution.

VII. *Issuance of Certificate:* The Department of Insurance shall issue a certificate of authority or license upon payment of a fee of $..... and upon being satisfied on the following points:

(a) That the applicant is established as a bona-fide non-profit hospital service corporation.
(b) That the contracts between the applicant and the participating hospitals obligate each hospital party to render service to which each subscriber may be entitled under the terms and conditions of the contract issued to the subscribers.
(c) That the rates charged and benefits to be provided are fair and reasonable.
(d) That amounts provided as working capital of the corporation are repayable only out of earned income paid and payable for operating expenses and hospital expenses and such reserve as the Department of Insurance deems adequate.
(e) That the amount of money actually available for working capital be sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the certificate.

VIII. *Reports:* Every such corporation shall annually on or before the first day of March (or the first day of June) file in the office of the Department of Insurance a statement verified by at least two of the principal officers of said corporation showing its condition on the 31st day of December, then next preceding, which shall be in such form and shall contain such matters as the Department shall prescribe.

XI. *Visitation:* The Department of Insurance may appoint any Deputy or Examiner or other person who may have the power of visitation and examination into the affairs of any such corporation and free access to all of the books, papers and documents that relate to the business of the corporation, and may summon and qualify witnesses under oath to examine its officers, agents or employees or other persons in relation to the affairs, transactions and conditions of the corporation.

X. *Expenses:* All acquisition and administrative expenses in connection with such hospital service corporation shall at all times be subject to the approval of the Department of Insurance.

XI. *Investments:* The funds of any corporation subject to the provisions of this act shall be invested only in securities permitted by the law of this state for the investment of assets of life insurance companies.

XII. *Disputes:* Any dispute arising between a corporation subject to the provisions of this act and any hospital with which such corporation has a contract for hospital service may be submitted to the Department of Insurance for its decision with respect thereto. Any decision and finding of the Department of Insurance made under the provisions of this act shall not be any bar to constituted legal procedure in a court of competent jurisdiction.

XIII. *Dissolution:* Any dissolution or liquidation of a corporation subject to the provisions of this act shall be conducted under the supervision of the Department of Insurance which shall have all power with respect thereto under the provisions of law with respect to the dissolution and liquidation of insurance companies.

XIV. *Taxation:* Every corporation subject to the provisions of this act is hereby declared to be a charitable and benevolent institution, and its funds, operations and properties shall be exempt from taxation.

## APPENDIX B

### STANDARDS FOR NON-PROFIT HOSPITAL SERVICE PLANS

Established by the Commission on Hospital Service of the American Hospital Association, January, 1938; revised September, 1939.

1. *The corporate body should include adequate representation of hospitals, the medical profession, and the general public.* Trustees or board members of the hospital service plan should receive no remuneration for service as trustees or board members. The interests and the responsibilities of participating hospitals make it desirable that a majority of the policy-making body be representatives of hospitals.

2. *No private investors should advance money in the capacity of stockholders or owners.* Initial working capital may be provided by individuals, hospitals, chests, councils or other civic agencies, but should be repayable only out of earned income, over and above operating expenses, payments to participating hospitals and legal reserve. No organizations or individuals advancing initial capital should attempt to influence or direct the management of hospital service plans because of their financial support. The hospital service plan should be independent of any other corporate body or professional or lay group.

3. *Plans should be established only where needs of a community are not adequately served by existing non-profit hospital service plans.* Opportunity should be given for all institutions of standing in each community to become member hospitals in a hospital service plan and subscribers should have free choice of hospital at the time of sickness.

4. *The hospital service benefits of a non-profit hospital service plan should be guaranteed by the member hospitals during the life of the subscriber-contract.* The ultimate economic responsibility for

service to subscribers enrolled at any given time should be assumed by the member hospitals, through definite contractual agreements with the hospital service plan. All contracts involving the plan, the subscribers and the member hospitals should be equitable and consistent with respect to the rights and obligations of each party.

(a) Benefits in member hospitals should be expressed in "service contracts," which describe specifically the types and amounts of hospital services to which the subscribers are entitled.

(b) A majority of the hospitals of standing should be member-hospitals in each area where a hospital service association enrolls subscribers, and arrangements should be made for provision of service in non-member hospitals.

(c) In case of physical impossibility to provide service in member-hospitals or others, equitable arrangements should be made for protection of the subscribers' interests.

(d) It is understood that State legislation may require modifications of these requirements.

5. *Subscription payments or dues received should be currently separated into "earned" and "unearned" income.* The earned income should be apportioned to special accounts each earmarked for special purposes, as follows:

(a) *Hospitalization:* For payments to participating hospitals. Charges against this account should include estimated payments for undischarged cases. (Desirably 60 to 80 per cent.)

(b) *Contingency Reserve:* In minimum ratios determined by law, or larger proportions designated by action of board of trustees. (Desirably from 5 to 10 per cent.)

(c) *Field Service and Administration Expense:* (Not exceeding 15 to 30 per cent.) The cumulative ratio of field service and administration expense to earned subscription payments or dues should not exceed 30 per cent for the first full year, and the monthly ratio should be considerably less by the end of the year. Ultimately the ratio should not exceed 15 per cent.

In the calculation of earned income from subscription payments or dues during a given fiscal period, only those cash receipts should be considered "earned" which apply to and are intended for the payment of hospital benefits and expenses during that period. When subscription payments or dues are received in advance of the fiscal period to which they apply, the "unearned" portion should be accurately determined and separately recorded in the accounting records.

The formulas for calculating unearned subscriptions established by the various State departments of insurance are, in general, acceptable to the Commission. Where a non-profit service plan is not supervised by the State Department of Insurance, the uniform procedure adopted by the Council on Hospital Service Plans is recommended. Details of this procedure can be obtained from the Commission on Hospital Service.

6. Statistics should be maintained currently as follows: (a) Number of subscribers (classified). (b) Number of hospital admissions (classified). (c) Number of patient days of care (classified). (d) Number of member-months (or member-years) of protection to subscribers (classified).

7. Initial working capital should be sufficient to carry all acquisition costs and operating expenses for a stated period (e.g., six months), after contracts first become effective, thus making earned income from subscriptions available in full for payments to hospitals during this period. Financial statements of operations and condition could be prepared by certified public accountants at regular intervals, at least annually.

8. The requirements for annual reapproval by the Commission shall be: (a) Maintenance of standards of organization and policies applied at time of original approval; (b) a substantial number of enrolled subscribers having in mind the possibilities of the area served; (c) a period of successful operation, with sound administrative procedures, usually not less than six months of enrollment activities; (d) financial status and operations which adequately protect the interests of subscribers and member hospitals.

9. Payments to hospitals should be based on the costs of services provided to subscribers in hospitals of that community, district or region. This does not preclude the possibility of developing public ward-service plans for employed groups with low incomes, and agreements by member hospitals to provide service at rates less than the full operating costs.

10. Employees of a non-profit hospital service plan should be reimbursed by salary as opposed to a commission basis. A private sales organization should not be given responsibility for promotion or administration on the basis of a percentage of premiums. Promotion and administrative policies should be dignified in nature, consistent with the professional ideals of the hospitals concerned, and in accord with economically sound practices as determined by actuarial and financial experience of the various plans.

11. In communities with only one hospital, the finances of a hospital service plan should be separate from the general budget of the hospital.

12. Hospital service provided through a hospital service plan should be determined by the practices of the member hospitals of the particular plan.

13. Hospital service plans should not interfere with existing relationships between physicians and hospitals or between physicians and patients.

14. A hospital service plan should meet with the general approval of the Commission on Hospital Service of the American Hospital Association.

# HOSPITAL SERVICE PLANS: THEIR CONTRACT PROVISIONS AND ADMINISTRATIVE PROCEDURES

MAURICE J. NORBY*

Hospital service plans have developed a form of protection which, when reduced to its simplest terms, means the application of the principle of collective cooperation to the equalization of losses resulting from the uncertainty of continued good health. It cannot be considered health insurance, inasmuch as it provides for the contingency of only one form of health service, namely, hospitalization. The fact that hospital service plans have enjoyed wide acceptance during their short lives has probably resulted from a realization that, wherever there is a contingency, the easiest and securest way of providing against it is by uniting with others so that each person may subject himself to a small deprivation in order that no individual may be subjected to a great immediate expense.

The American Hospital Association endorsed the principle of prepayment plans for hospital care in February, 1933. At that time, the Association established the following set of principles which it felt should characterize such plans: (1) emphasis on public welfare; (2) limitation to the provision of hospital service; (3) enlistment of professional and public interest; (4) free choice of physician and hospital; (5) non-profit organization; (6) economic soundness; and (7) dignified promotion and administration. These principles later formed the basis of an approval program which is administered by the Commission on Hospital Service of the American Hospital Association.

### *The Corporation*

The operation of a hospital service plan is effected through a corporation which is established in conformity with local legislation. The corporation usually is organized as an agency which undertakes to establish, maintain, and operate a plan whereby hospitalization may be provided to subscribers in any hospital with which the corporation may contract for such service. In several communities, the plan corporation is actually an organization of hospitals which appoints the service association as its agent to operate the plan under its supervision and direction. Under this type of organization, the subscribers to the plan have no right, claim or cause of action either

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at law or in equity against the service association, but must make complaints directly against member hospitals. In actual operations, the net result of either type of organization is the same. In the first instance, the subscribing public contracts with the hospital service corporation, which is an agency not producing or having control of hospital service but which contracts with hospitals to provide the specified benefits. In the second instance, the public actually contracts with the source of the hospital service which will be provided to them in accordance with contractual agreements.

Eligibility for membership in hospital service plan corporations does not take a definite pattern. In several communities any person interested in the promotion of proper health service is eligible for membership in the corporation. Such individuals may be elected to office without regard to their actual association with hospitals or other health agencies. Other corporations specify that membership in the corporation must be equally divided between the interests of hospitals, the medical profession, and the public. Several hospital service plan corporations limit membership to representatives of hospitals only. In these corporations membership is usually divided between hospital administrators and hospital trustees.

The responsibilities of participating hospitals make it desirable that their interests be protected; therefore, a majority of the membership of the board of directors is usually representative of such hospitals. It has been found desirable so to constitute the governing bodies that the representatives of hospitals or medical profession or public may not pursue selfish interests to the detriment of the plan.

The by-laws of the corporation usually provide for a board of directors to administer the activities of the corporation. This board may be elected from the membership of the corporation, or may be designated as the total membership of the corporation. If specific representation of hospitals, medical societies, and public is required in the membership in the corporation, this same proportion of representation is usually designated for membership on the board of directors.

*Hospital Service Plan Administration*

The management of a hospital service plan is similar to that of proprietary business. An executive officer, who is responsible to the board of directors, is usually in direct administrative control of the organization. Theoretically he is in charge of all departments of the organization. In practice, however, as the plan grows in size, he usually centers his attention on the coordination of the various phases of the enterprise and appoints subordinate officers to direct activities in specialized departments. Unlike commercial insurance and private business, this executive officer is usually not a member of the board of directors. Although he is responsible for the success of the venture, his opinions, in a majority of the plans, are not democratically represented on the governing board.

The administrative organization of a hospital service plan usually includes the following departments: (1) the field service and acquisition department, the first duty of which is to secure new business for the corporation; (2) the contract or underwriting department, which examines statements of the applicant, issues sub-

scriber contracts and establishes office records on each new account; (3) the hospital department, which receives all notifications of hospital admissions from member hospitals and accepts or rejects liability for such care; (4) the comptroller's department, which handles the accounting and financial records of the corporation; (5) the cashiering department, which receives all income to the corporation and maintains a current record of receipts; (6) the actuarial and statistical department, which prepares experience tables for use in analyzing the results of the corporation activities; (7) the tabulating department (in large organizations), which mechanically produces information from existing records and prepares reports upon order from various department heads; (8) the educational and publicity department, which maintains a proper relationship between the corporation and the public, and effects the promotional program; (9) the purchasing and supply department; (10) the mailing department, and (11) the personnel department, the functions of which are obvious, and which are usually instituted only in large organizations.

*Hospital Contracts*

The hospitals which desire to participate in hospital service plans apply to become members and agree that, in consideration of the corporation's payment of a fixed amount of money per day for hospital services rendered to subscribers to the plan, they will render such services to subscribers and abide by the provisions of the subscriber's contract. The amounts of the *per diem* payments are subject at all times to the determination of the board of directors and the approval of the regulatory bodies in those states where regulation is specified by enabling legislation.

The hospital contract is usually a restatement of the subscriber contract, with the further provision that the contracting hospital shall be liable for the provision of hospital service regardless of the financial ability of the corporation to pay that hospital for services rendered. It has been established that some agency must be responsible for the fulfillment of the terms of the subscriber contract. Three ways of effecting such a guaranty are possible: an assessment feature in the subscriber contract; a surplus guaranty fund available for the purchase of hospital care; or a subscriber contract underwritten by a responsible agency.

Mutual and stock insurance companies use one or the other, or a combination of both, of the first two possibilities. Hospital service plans operate under legislation which does not require, and in some instances does not permit, the establishment of either of these two safeguards for subscribers. If hospital service plans occupy a unique position, it is because of their ability to offer a "service contract" by virtue of a financial guaranty by participating hospitals. This guaranty, therefore, must be assumed by the member hospitals through which the service specified in the subscriber contract is made available. Such a regulation is a public safeguard.

In certain plans, this financial responsibility extends not alone for the provision of hospital service to subscribers but also to the continued operation of the plan in paying current operating expenses. The following definition of hospital responsibility is a quotation from "The Standards for Non-Profit Hospital Service Plans" which

have been established by the Commission on Hospital Service of the American Hospital Association.

"The hospital service benefits of a non-profit hospital service plan should be guaranteed by the member hospitals during the life of the subscriber's contract. The ultimate economic responsibility for service to subscribers enrolled within any given time should be assumed by the member hospitals through definite contractual agreement with the hospital service plan. All contracts involving the plan, the subscribers and the member hospitals should be equitable and consistent with respect to the rights and the obligations of each party."

The hospital contract is usually cancellable in a manner which provides the corporation an opportunity to terminate its obligation to subscribers. That is, if the subscriber contract is cancellable on a 30-day notice, usually the hospital contract is cancellable on 60 days' notice. If the subscriber contract must continue in effect until the end of the contract year, the hospital contract is cancellable on 13 months' notice. During this period, however, the obligation of the hospital continues in effect for all contract holders only until the termination of the subscription years of the contracts in effect on the date of notification of cancellation by the hospital.

In case of liquidation of the assets of the corporation, either the corporation continues to provide hospital service to its membership without collecting further dues from and after the date set for liquidation until all surplus accounts have been dissipated through the provision of hospital service or all surplus funds are divided *pro rata* among member hospitals in accordance with the amount of hospital service which has been provided during a specified period prior to the date of liquidation.

*The Subscriber Contract and its Duration*

The agreement with the subscriber is a contract whereby the corporation agrees to provide certain hospital services the need for which may arise from some contingent event. Inasmuch as the contract is not issued upon the strength of a medical examination, but rather in accordance with a statement by the applicant to the effect that he or she knows of no need for immediate hospital care on the date of application, the corporation is not obligated to provide such hospital service resulting from a false warranty. The contract is valid only if there is present the specific element of risk which the corporation assumes.

The contract specifies a provision of service and not a cash indemnity. It carries the name of the person or persons entitled to benefits in accordance with the terms and provisions enumerated and indicates the manner in which additional family members may be added to the contract, if they are covered by the plan. It defines the extent and duration of hospital service, the manner and amount of periodic subscription payments, conditions affecting the provision of hospital service, the manner in which the contract may be terminated, the effective date of membership, and other information affecting the relationship between the subscribers and the corporation.

The benefits included in the contract are described in the succeeding section. In no instance do they include the services of a subscriber's attending physician, surgeon, special nurses or their board. The free choice of physician and hospital remains with the subscriber. Hospital services are rendered by the corporation only upon compliance with rules and regulations of the hospital selected for service.

Most contracts provide that if at the time the subscriber applies for hospital service, the member hospital selected for use is unable to furnish the required service, the subscriber, with the consent of his physician, is free to utilize the services of another member hospital. Usually the liability of the corporation is satisfied by refunding the amount of all subscriber's prepayments on such date as it is established that all member hospitals, because of overcrowded conditions or for other reasons, are unable to accept subscribers for service. In some instances, the plan provides the subscriber with a cash *per diem* payment during the period he is unable to receive hospital care in a hospital.

Usually benefits are limited to the contract year, defined as a 12-month period from and after the effective date of the contract. The benefits of the plan are not assignable and are personal to the subscriber. The hospital service plan corporations, with one exception, are not subrogated to the rights of subscribers who may also recover from any person or persons other than the corporation or any member hospital for service rendered under the contract.

The amount and manner of payment of the annual charges may or may not be stated in the subscriber contract. These charges are usually subject to revision from time to time by the directors of the corporation. In the event of a change, the subscribers must be notified. This change usually does not affect the amount of the annual charges under existing agreements, until the end of the contract year. Prior to that time, the subscriber is required to sign a new application setting forth the amount of the new charges. If the subscriber fails to execute such an application, his contract, by contract provision, will automatically terminate at the end of his contract year.

All contracts issued by hospital service plans are cancellable, although the period of cancellation varies. Without exception, the contract may be cancelled on a monthly basis by the subscriber by reason of default in payment, by reason of request for cancellation, or by reason of subscriber's death. Some subscriber contracts provide for cancellation by the corporation on 30 days' notice; others provide for cancellation only upon the termination of the subscription year. Usually the agreement may be reinstated by the subscriber after it has been cancelled if he meets specific regulations established by the corporation. In certain plans the subscribers who request reinstatement of their contracts must pay reinstatement fees plus unpaid subscription dues accumulated during the period of delinquency; and in others the subscriber's reapplication is subject to a waiting period before benefits are available.

The printed contract constitutes the entire agreement between the corporation and

the subscriber. No employee is authorized to change the terms of the contract or to make verbal exceptions to its contents.

*Scope of Benefits to Contract Holders*

Hospital benefits are usually provided for all types of illness and injuries which are regularly treated in member hospitals. In some plans, benefits are available for all types of illnesses on and after the effective date of the contract. In others, waiting periods ranging from ten days to six months are effective for all elective hospitalization, with immediate benefits available only for accidental injuries and illnesses which in the opinion of the medical adviser were unpredictable and in the nature of an emergency. With the exception of one plan, the plans exclude from benefits all conditions known to the subscriber to exist and to require hospital care on the date of application. Out-patient or ambulatory care, excepting for cases of accidental injury, is not generally provided.

Usually such conditions as pulmonary tuberculosis (after diagnosis), venereal diseases, quarantinable diseases, and mental disorders are not acceptable illnesses for which the subscriber may claim benefits under the hospital service plan. These conditions are either long-term illnesses or the general hospital is not equipped to render service for them. They have been excluded from benefits on this basis. Hospitalization for which the subscriber is entitled to workmen's compensation benefits, has without exception been excluded from the benefits of plans on the ground that this contingency is provided for by law.

The nature of the hospital care described in the subscriber's contract is not the same in all plans. Hospital policies vary in various locations, and the definition of hospital care conforms to common practice under local conditions. In all communities bed and board and routine nursing service are considered a part of hospital care and, therefore, hospital service plans without exception provide these benefits. Usually a maximum of 21 days of hospital care may be used by the subscriber during any one contract year in one or more hospital admissions for one or more illnesses. Several plans have provided for 30 days of service and several extend the period of hospitalization year by year as an inducement to the subscriber to continue his membership. The majority of the plans to date have provided semi-private accommodations to contract holders. The term "semi-private accommodations" usually refers to a two- or a four-bed room. However, in some plans this classification may include any multiple bed accommodations in which the patient is free to choose his own medical adviser. Although the type of accommodations provided is defined as semi-private, the subscriber patient has the privilege of using either less or more expensive accommodations. If private room accommodations are elected, then, upon the approval of the patient's attending physician, the subscriber is entitled to a cash allowance which is applied toward the purchase of the more expensive room. In certain instances, a subscriber patient's economic status may be such that without membership in the plan, he would be considered medically indigent by the social service department of the hospital. In order that this patient may still have the privilege of

free medical service, the member hospitals in these plans may upon his own request, provide him with ward accommodations and the privilege of using a house physician. If the subscribing patient uses ward accommodations in place of semi-private service which is more expensive, he does not receive the credit of the cash difference between the cost of these two types of accommodations.

The special hospital services which are provided as benefits usually are the same regardless of what type of room accommodations the subscribing patient elects to use, although in one instance a straight cash credit is provided to that patient who elects to use private rather than semi-private accommodations, and in another instance certain limitations on amount of special service are placed on private room service for the subscriber patient.

Recently several communities have established ward service contracts which are sold at a lower cost than semi-private service contracts. However, the cost probably has not been reduced to a point where it will be attractive to the majority of the very low income workers. Hospital service plans have enrolled primarily the upper middle-income group. It is felt that if they wish to serve adequately the greatest need, they must extend their services to include people who are self-supporting but who are not in a position to provide either themselves or their families with what might be termed a "luxury" health service.

Usually the use of the operating room is specified as a contract benefit without regard to number of times its use becomes necessary. Likewise, in a majority of the plans anesthesia is provided if it is administered by a salaried employee of the hospital. The contract specifies the provision of ordinary dressings, drugs, and laboratory work. The indefiniteness of this description has led to considerable controversy and misunderstanding on the part of the subscribing public. Recent tendencies are to provide all surgical dressings, plaster casts, splints, etc., to provide only drugs which are listed in the pharmacopoeia, and to define "laboratory service" by specifying certain definite procedures.

Plans which provide physiotherapy and X-ray service about equal in number those which do not. In one plan, X-ray service is provided to an amount not to exceed $15.00, and a 25% discount is allowed on all X-ray service beyond that maximum charge.

The benefits usually do not include admission of patients to member hospitals for laboratory or X-ray examinations solely for diagnostic purposes. This limitation of service has been difficult to administer, inasmuch as there is no definite division between diagnostic and therapeutic service. Some plans have determined that a patient shall be eligible for benefits regardless of the type of service which he receives in the hospital, if he remains in a hospital bed for 24 hours or more. Other plans have excluded all procedures used in conjunction with diagnostic services, even though they also may be prescribed for therapeutic service.

Although hospital service plans usually provide hospital service rather than cash reimbursement, in certain instances the service element of the contract is limited.

One plan indemnifies subscribing patients against specialized hospital services and actually reimburses him in cash for expenses incurred in these departments of the hospital. In other communities, indemnifications for incidental professional services are handled as bookkeeping entries on the ledgers of the hospital service plan; but no actual cash payments to patients, hospitals, or doctors are made from these entries.

A majority of plans provide obstetrical care after the subscriber has been a member of the plan for a period varying from nine months in some plans to one year in others. The use of the delivery room, if obstetrical care is covered, care of newborn children and attendant service is provided as for a regular hospital illness. Certain difficulties of interpretation of the contract have arisen in a number of plans concerning the "waiting period" because the statement of what was included in maternity service was indefinite. In the past, most plans have excluded from maternity service all conditions resulting from pregnancy during the period of pregnancy and, in certain instances, all conditions resulting from childbirth, whether it was a result of a previous or a current pregnancy. A number of plans have interpreted miscarriages, ectopic pregnancies, etc., as accidental occurrences and, therefore, serviceable under the terms of the hospital service plan.

It is the ambition of hospital service plans to provide the patient with a receipted hospital bill when he leaves the institution. A contract providing such all-inclusive benefits would obviously be acceptable to the subscribing public and equally advantageous from the point of view of the hospital, the medical profession, and the plan.

*Public Relations and Promotion*

The essence of success of hospital service plans is not salesmanship; rather, it is a program of sound public relations. Inasmuch as the means of obtaining publicity are manifold, the questions of policy and acceptability of the plan in the community are of prime importance. Assuming that the plan meets and serves a definite need in the community, the public relations program is one of education. Such a program is fundamentally one of interpreting the position of the voluntary hospital in the community. The public respects the hospital organization. Hospital activities can easily be dramatized. The public owns the hospital, the public supports the hospital, the public must accept the hospital service plan as an adjunct to the hospital.

When the community has recognized the plan as a hospital-sponsored project and when a substantial part of the community has enrolled in the plan, the public relations program is even more important. It continues to stimulate local pride in its success, to arouse confidence, to create public demand, to educate special groups, and is mindful of the opportunity of improved relations with the public, the medical profession, and the hospital personnel. The educational program is dignified, constructive and purposeful. It reflects the character of its sponsors, the voluntary hospitals. At the same time, it carries no connotation of charity, but constantly reminds the public that, through this agency, they are themselves preparing for unpredictable hospital expense and that the means which they have chosen is self-sustaining. All

agencies used in dignified promotional programs are enlisted in a public relations and educational program for hospital service plans.

*Enrollment Practice*

Membership in hospital service plans is usually available to employed people through their places of business on a group basis. A group is usually considered for membership regardless of size, if it is constituted of individuals working under the direction of a common employer. Usually the subscription rates are paid in full by the subscribers to the plan. In rare instances the employer pays the entire charges and only occasionally are payments made on a contributory basis with the employer carrying a partial responsibility for payment. Some plans do not permit employer contributions. Groups are formed by voluntary action on the part of employees. It is not reasonable to expect voluntary action from 100% of any class of employees on any proposition; therefore, minimum percentages of participation have been established by individual plans. In some localities, this minimum has been determined as 25% of the total number of employees in an organization. Recently one of the oldest and largest plans has set a minimum requirement of 75% participation before a group may be formed. Those in the employ of a company are not divided according to class rule, such as economic status or term of employment.

The employer's cooperation is necessary to present the program to his employees and to facilitate subscription payments by establishing a salary deduction procedure for this purpose. Plan directors, after experimentation, have concluded that payment through salary deduction is the most satisfactory method both from the point of view of the subscriber and of the plan management. A procedure less satisfactory, but necessary for governmental groups, is one by which the subscribing group makes its payment to the association through an individual who acts as treasurer for the group. It has been found least satisfactory to permit individuals to make payments directly to the association.

Before a group can be enrolled, the theory and practice of the hospital service plan must be explained in detail to the employer. If the proposal meets with his approval, a representative of the plan meets with the employees, preferably on company time, in a group meeting and explains the details of the service to them. The employees are given an opportunity to ask questions and to discuss the merits of the program. Literature describing the plan, and application blanks, are distributed. Employees are instructed to consider the proposition carefully and to return signed application blanks to a designated person on or before a closing date which has previously been established. During the interval between the first presentation of the plan and the closing date, additional literature, placards describing the plan and sometimes conferences with individuals are made available to describe the service more adequately to those who wish further clarification. On the closing date, the application cards are collected, tabulated, and either accepted or rejected, depending upon whether or not they meet the requirements for the organization of a group.

Group enrollment is necessary because no medical examination is required before the applicant is accepted to participate. It is expected that a certain percentage of individuals in need of immediate hospital care will enroll with the initial group. However, because of the group requirements, the strong support the weak. The size of the group does not seem particularly important in its relation to utilization of hospital service. Very small groups can be enrolled safely at slightly higher percentages of participation if the individuals are sold plan membership rather than permitted to buy it. A requirement for high percentage of participation eliminates self-selection against the hospital service plan because it minimizes the likelihood that employees, conscious of good health, will elect to withhold their membership to the material detriment of their fellow employees.

In a few instances, social groups have been permitted to organize for purposes of membership in a hospital service plan, and employee associations, labor unions, lodges, and church groups have been enrolled in several plans. They do not represent the same type of selection as the enrollment of employed people through places of business. Acceptance of this type of group is not general. They are enrolled subject to the judgment of individual plan directors. It has been determined that groups of individuals who have associated themselves solely for the purpose of meeting group requirements for membership in a hospital service plan do not represent a cross section of the population and ultimately use an excessive amount of hospital care.

Several plans have attempted to enroll individuals. In some such plans, these individuals have paid a slightly higher subscription rate than that charged to employed persons enrolled through groups in places of business. In other plans the individually-enrolled person has been required to complete a detailed health questionnaire. Generally speaking, non-profit hospital service plans have discontinued the enrollment of subscribers on an individual basis. No formula has yet been devised which will guarantee utilization of hospital service by this group at a rate which is not in excess of that experienced with the general public. If the plans are attempting to provide complete coverage of employed workers, at a price which they can afford to pay, it seems to require a mass scheme applied in a mass way.

*Coverage for Family Members*

Hospital benefits provided to family members of subscribers have varied from those plans in which only the employed person is permitted to enroll with no opportunity to protect dependent family members to those plans in which family members are entitled to the same benefits as those which are specified for the employed subscriber.

A number of plans do not provide the same type of benefit for the family participants as they do for the employed individual. These plans have been classified as "partial coverage plans." Partial coverage is a relative term in that it refers to coverage which is not provided in the same proportion to dependents as it is to the applicant subscriber. It has been provided in one or the other of the following two ways: Either the patient is entitled to a straight percentage reduction on the total

cost of hospital benefits which are provided for the applicant subscriber or he is required to pay a flat *per diem* payment to the hospital during his stay for which he receives the same benefits as those specified for the subscriber.

There can be no question of the desirability of full family member coverage from the standpoint of the subscriber. The public is interested in protecting itself in full against the contingency of hospital care. Two aspects of the problem which have been considered before determining which program to adopt are: (1) Is full family member coverage financially sound? (2) Is the average wage of the employed person in localities where full family member coverage is to be offered, high enough to finance the additional subscription payment which is necessary to maintain economic soundness?

Although it is generally felt that a full coverage program tends toward frivolous use of hospital services, in general it can be said that a liberalization of subscriber contracts apparently improves the selection among subscribers so that a disadvantage on one hand is probably offset by an advantage on the other. The general experience in the larger urban areas has been that plans without full family coverage have not been as acceptable as those which did not limit benefits for family members. Plans which have been organized during the past two years have without exception included some type of coverage for family members, the tendency being to initiate the plan with full family protection.

*Subscription Charges*

The subscription charges represent the source of income to the hospital service plan and must be adequate to pay for hospitalization of subscribers and administrative costs. Although it is generally assumed that the membership in a hospital service plan will represent a cross sectional average of the population, this is not always the case in a system where the membership is acquired on a voluntary basis. Therefore, the subscription rate is weighted to meet this variable.

The amount of hospital service used in any section of the country will not necessarily be the same as the national average. For this reason morbidity statistics compiled in the area contemplating the initiation of the hospital service plan have been the basis for the determination of the expected utilization of hospital service by the subscribing population. When the amount of hospitalization which the plan expects to provide to subscribers has been determined in terms of days, the cost of this service has been calculated on the basis of hospital costs in the communities to be served. To this figure is added the estimated cost of administering the plan and an amount to be set aside in a reserve account to be used at a later time in cases of emergency.

Obviously, the scope of benefits determine the cost of hospital service. Therefore, rates in various communities are influenced by this consideration.

It has been found that unemployed people use more hospital service than employed subscribers, that employed females use approximately 50% more hospital service than employed males, that unemployed females use about twice as much hos-

pital care as employed males, and that dependent children use approximately two-thirds the number of hospital days per year as employed males. Therefore, the selection of subscribers, more than any other single factor, affects the amount of hospital care which the plan expects to provide. If the plan enrolls subscribers only through their places of business, and accepts family members on a full coverage basis, it has been established that one day of hospital care per person, or three days of hospital care per family unit is a conservative estimate of utilization.

A hospital service plan expects to use no more than 20% of its earned income for the administration of the plan and ultimately this cost should be reduced to the neighborhood of 10% as the plan progresses in age and size. It has been recommended that from five to ten percent of earned income is adequate for contingency reserves. If these percentages are applied to an expected average *per diem* hospital cost of $6, annual premiums of $7.50 for an employed person, $15 for a husband and wife contract, and $22.50 for a family contract are adequate to meet anticipated liabilities.

In some communities, the rate for the applicant subscriber has been determined and each family member listed for coverage has been charged an additional amount equal to that paid by the applicant subscriber. This arrangement has not proven particularly acceptable to the public and has led to adverse selection of risks which has militated against the plan. One of the first plans to initiate a hospital service program was set up on a two-rate basis, *i.e.*, one rate for the single individual and another rate for the family group, regardless of whether that family included only husband and wife, or husband, wife and children. The family rate was established approximately midway between the theoretical charges which were calculated for husband and wife and family contracts.

The common practice has been to charge a proportionately high individual subscriber rate and a decreased family rate, because it is obviously more difficult for a person with a family to pay a higher rate for family protection than it is for a single individual to provide for his own protection. This arrangement seems the most satisfactory both from the standpoint of the public and the service plan. With a rate structure built on this basis, it is not necessarily true that all contracts in all classifications are self-sustaining. The large family group is expected to use more hospital care than the small family unit, and ultimately to produce a deficit account for this classification. Conversely, the small family units develop a surplus account. Inasmuch as a head of a large family is less able to provide adequate hospitalization for his family members and because the object of hospital service plans is to provide the general public with more adequate hospital care, the establishment of a single rate for family members probably serves the more useful social purpose.

*Special Problems*

*Reciprocity of Benefits:* Several plans have developed reciprocal arrangements whereby a subscriber to one plan may use a member hospital in another plan and receive the full benefits of his "service" contract. However, subscribers to most plans

who find it necessary to use non-member hospitals in cases of accident or emergency are provided cash *per diem* allowances. Often this fixed amount does not adequately meet the costs of the emergency hospitalization. Although complete and general reciprocity of benefits is desirable, probably it will be some time before such an agreement will be in active operation since each plan is slightly different in character and benefits.

*Preferential Rates:* Up to the present time, hospital service plans have based their rate structures upon the anticipated utilization of hospital service for the community as a whole. From time to time certain large employee organizations representing "selected risk" groups have suggested participation in plans on a cost-plus basis. The plans have felt that if their project is one community-wide in nature, no special consideration could be given to units making up the community. As a result several large organizations have declined to participate in the community program and have established hospital benefits as a part of an employees' benefit society or as a special project administered in conjunction with credit unions.

*Definition of Hospital Service:* Certain groups within the medical profession have objected to the provision of medical services incident to hospitalization which are provided to hospitalized bed patients by hospital employees. These include such services as physiotherapy, X-ray, laboratory procedures and anesthesia which in most hospitals are charged to the patient as a part of his regular hospital bill.

It has not been the intention nor the performance of plan directors to practice medicine or to administer hospitals. They have devised a means by which the burden of hospital expense can be lifted from the individual, and it is their desire to include as benefits all items of hospital expense which, prior to the organization of the plan, were recognized as a part of hospital service and charged as such to hospitalized patients. If it is not objectionable for the hospital to bill the patient directly for such service, it is not logical to object to the means employed by the patient in making his remittance.

The ultimate decision as to what constitutes hospital and medical service usually rests with the definitions of such which are found in the medical practice acts of the various states.

### *Growth and Expansion*

The membership in approved hospital service plans has progressed rapidly. The enrollment on January 1, 1933, was 200,000; on January 1, 1938, 1,500,000; on July 1, 1939, 4,000,000; and enrollment on January 1, 1940, will probably exceed 5,000,000 participants. Through their growth, the plans have demonstrated the demand for security against the unpredictable expense of health service.

Hospital service plans provide for the contingency of only one form of health service. The purchase of medical service on a similar basis would be desirable and undoubtedly acceptable to the public. A joint hospital and medical program, through the agency of voluntary prepayment plans, could more adequately serve the health needs of the people.

Particular emphasis is being placed upon the adaptation of these plans to the needs of the low income workers. Such a consideration raises special problems. It appears necessary that there be an integration of the public agencies for the support of plans which serve this class of employee. It may be necessary and desirable for hospitals to subsidize ward plans for patients who, without participation, would otherwise receive charity care. Ward plans must include a provision for medical service to serve the needs of this group adequately.

With the solution of these problems, voluntary plans will be better able to serve a greater number of people; they will have adjusted themselves to the needs of the public; and they will not ultimately emerge from their metamorphic development as a legislated creation with the attendant influences of political control.

# THE MICHIGAN ENABLING ACT FOR NON-PROFIT MEDICAL CARE PLANS*

WILLIAM J. BURNS†

"Michigan's Doctors Offer Low Cost Family Service," shouted newspaper headlines throughout the Wolverine State last September 19. "A group medical care plan for families with limited incomes was adopted yesterday by the Michigan State Medical Society," the news story stated. "It will make available to participating groups a wide range of medical services at nominal cost."

While the press with generous columns heralded this action as an answer to the medical economic problem, some gentlemen of the fourth estate suggested the medical profession was taking a very revolutionary plunge. Few stories presented the background of nine years of study and research by the Michigan State Medical Society preceding its final decision to adopt a plan for assisting those in the lower income groups to obtain needed medical service. And only one or two reporters mentioned the Michigan Enabling Act[1] upon which the whole new structure rests!

## ENABLING ACT FOR GROUP MEDICAL CARE

In 1934, the Michigan State Medical Society began its pioneer study of the distribution of medical services in Michigan. After almost a decade of research costing approximately $30,000, which emphasized the vital need for a firm legal foundation for any medical service plan, the Society gave authority to its Committee on Legislation to develop a group medical care bill for introduction in the state legislature. This significant proposal was carefully drafted and re-drafted, revised and corrected, and finally presented to the Michigan legislature on February 20, 1939. It was approved by the House of Representatives four weeks later, passed by the Senate on May 4th, and signed by the Governor on May 17th. Given immediate effect, this Michigan law represented the first group medical care enabling act on the statute books of a large industrial state. As will be seen, its passage was not uneventful.

* This article will consider only the Enabling Act and its legislative history and not the plan recently adopted under the authority conferred by the Act. For a description of a state medical care plan established under professional auspices, see Peart and Hassard, *The Organization of California Physicians' Service*, *infra*, p. 565. ED.

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[1] Mich. Acts 1939, act No. 108.

### RÉSUMÉ OF THE ORIGINAL BILL

The measure as introduced represented the joint thinking of a voluntary group and a branch of the state government, the Michigan State Medical Society and the Michigan Department of Insurance, to which the physicians applied for help with technical questions. A digest of House Bill No. 215 follows, the sections drafted by the Department of Insurance being indicated by an asterisk:

*Section 1.* Intent of act: "to promote a wider distribution of medical care, and to maintain the standing and promote the progress of the science and art of medicine in this state."

*Section 2.* General purposes: Act permits formation of a corporation to establish, maintain, and operate a voluntary non-profit medical care plan whereby subscribers, by paying a small monthly fee, are entitled to medical and surgical care, appliances and supplies, in their homes, in hospitals, and in physicians' offices. Such other benefits may be added from time to time as the corporation may determine. The plan is subject to supervision by Commissioner of Insurance in order to protect the interests of subscribers.

*Section 3.** Manner of subscribing to articles of incorporation.

*Section 4.** Fees which must be paid upon incorporation.

*Section 5.** Plan to be submitted to Commissioner of Insurance for approval.

*Section 6.** Commissioner of Insurance may inspect records of corporation.

*Section 7.** Annual report shall be filed with the Insurance Commissioner.

*Section 8.* Board of Directors shall have representation from medical profession and the public.

*Section 9.* Corporation has authority to provide all medical benefits, but may divide benefits into classes or kinds, and limit same in quantity, and to certain areas.[2]

*Section 10.* Each doctor has the right to register with the corporation to provide medical service. The physician-patient relationship shall be maintained. No restrictions shall be imposed on a doctor of medicine as to methods of diagnosis or treatment.

*Section 11.** Provision for reasonable reserves. Funds shall be invested only in securities permitted life insurance companies.

*Section 12.* Medical care shall be in accordance with accepted medical practice in the community.

*Section 13.* Payments in whole or in part may be made in behalf of indigent and borderline subscribers by private corporations, associations, groups, individuals and in behalf of indigents by governmental agencies; but each contract shall be with the subscriber (the patient), so that no third party comes between patient and physician.

*Section 14.* No action at law based upon or arising out of the physician-patient relationship shall be maintained against a non-profit medical care corporation.

*Section 15.* The corporation is not an insurance company but "is hereby declared to be a charitable and benevolent institution," free from taxation.[3]

*Section 16.* Violation of provisions of act constitutes a misdemeanor.

*Section 17.* Severability clause.

### CHANGES MADE BY THE LEGISLATURE

The bill's progress through Michigan's two legislative houses was stormy. At no time was any question raised concerning the merits of the proposal, but the issue was beclouded by the aggressive lobby of a group of healers (not doctors of medicine)

[2] The purpose of authorizing classification of benefits as to kind, quantity, and area was to permit experimentation in the formative stage.

[3] Tax exemption will result in greater benefits to the subscribers.

who desired to be included in this purely medical program. To have acceded to their desires would have lost the support of Michigan's 6,143 doctors of medicine who were interested in and working for this social experiment. However, after several major engagements, the Legislature passed the bill without any damaging amendments.

To help differentiate group medical care programs from insurance contracts, the insurance lobby suggested the inclusion of two clauses in Sections 2 and 3, a request which was readily granted. The addition to Section 2 reads as follows: "No contract by or on behalf of any non-profit medical care corporation shall provide for the payment of any cash or other material benefit by that corporation to the subscriber or his estate on account of death, illness or injury, nor be in any way related to the payment of any such benefit by any other agency." The following provision was added to Section 3: "The persons so associating shall subscribe to articles of association which shall contain the name by which the corporation shall be known, such name not to include the words insurance, casualty, surety, health and accident, mutual or other words descriptive of the insurance or surety business, and such name shall not be sufficiently similar to that of any insurance or surety company doing business in this or other states at the time of incorporation, to tend to create confusion in identity therewith, in the judgment of the commissioner of insurance."

A supporting clause was recommended by the Insurance Department for Section 2 to the effect "that the provisions of the Michigan Non-Profit Corporation Law[4] shall be applicable to all corporations formed under or governed by this act, except as herein otherwise specifically provided."

Finally, the legislature strengthened the provision permitting free choice of doctor, by adding the following penalty clause to Section 10: "Any employee, agent, officer or member of the board of directors of any such corporation who shall influence or attempt to influence any person in the choosing and selecting of his own physician, shall be guilty of a misdemeanor, and upon conviction thereof shall be punished as provided by the laws of this state."

## LEGAL QUESTIONS CONSIDERED IN CONNECTION WITH THE ACT

A new era in medical legislation began with the passage of the Michigan Act authorizing and regulating the incorporation of non-profit medical care plans. Formerly it was generally held that medical service plans need not be organized under existing insurance laws and that special enabling legislation was not necessary. Following the lead of Michigan, state after state has focused attention on the legality of medical service plans being operated without the benefit of legislation or without qualifying under the insurance laws.

The primary legal problem involves the question of whether a medical service plan should be subjected to special regulation as insurance or whether such a plan should be considered merely as a service agreement. The essential consideration is the importance of the undertaking from the point of view of the public and the

[4] Mich. Acts 1931, act No. 327, §§117-132.

likelihood that the organization promising to make provision for medical services will be able to perform the agreement. The first step toward regulation was to insist that medical service plans should qualify under the insurance laws which are specifically designed to protect persons who purchase contracts offering future benefits. Without a special enabling act, the distinction between a medical service contract and an insurance contract is difficult to draw. In addition, there were two obstacles to the organization of medical service plans under insurance regulations: the requirement of large capital funds, and taxation. The purpose of the Enabling Act is to create special regulations governing the operation of medical service plans, to place them under the supervision of the Commissioner of Insurance—but to remove the obstacles to regulation under the insurance laws. The Michigan Enabling Act accomplished this purpose and definitely established the special status of medical service plans.

A second important legal problem deals with the question of the corporate practice of medicine. Courts have generally held that the corporate practice of a profession is undesirable and illegal. Consequently, the undertaking by a corporation to arrange for the obtaining of professional services calls for careful analysis of the effect on established legal principles and related laws, such as the medical practice act. In the Michigan Enabling Act, considerable study was given to the phrasing of Section 2 in order to indicate clearly that the corporation itself was not authorized to engage in the practice of medicine but merely to be a fiscal agent for the subscriber and for the physicians: ". . . medical care is provided *at the expense of such corporation* to such person or groups of persons of low income as shall become subscribers to such plan." The Act does not state that medical care is to be provided by the corporation, but only "at the expense of such corporation." Medical care will continue to be provided by licensed and registered doctors of medicine in the same manner as private medical practice is now carried on.

A third essential legal problem involves the responsibility of physicians under the medical service plan. One aspect of this responsibility deals with liability for malpractice. Again, the existing legal attitude places responsibility for malpractice on the individual physician. Whether this responsibility can or should be assumed by corporations requires the full consideration of many far-reaching consequences. In Section 14 of the Michigan Act, the liability for alleged malpractice remains with the individual physician, where it properly belongs.

Another aspect of the responsibility of physicians pertains to their liability for fulfillment of services offered as benefits under the medical service contract. The basic liability for the services offered would seemingly repose with the corporation issuing the medical service contracts. However, most medical service corporations depend on an agreement with participating physicians for the provision of the services offered as benefits. Although the Michigan Act specifically provides in Section 12 that "all medical care rendered on behalf of a non-profit medical care corporation shall be in accordance with the accepted medical practice in the community at all times," and states in Section 10 that "a non-profit medical care corporation shall

impose no restrictions on the doctors of medicine who treat its subscribers as to methods of diagnosis or treatment," nevertheless, despite the usual ethical controls, some legal problems may perhaps arise concerning the responsibility of physicians to the corporation and to the subscriber entitled to benefits under a medical service contract.

### A SOCIAL RESPONSIBILITY FEELINGLY MET

Michigan's Act No. 108 of 1939 is the result of nine years' labor and education by the Michigan State Medical Society. It represents an evolutionary step forward. Michigan's doctors hope it will aid them in their difficult task of distributing quality medical care to all. The public has placed its faith in the medical profession; and the attitude of the press is best epitomized by the following sentence from one of the many eulogistic editorials on the group medical care plan of the Michigan State Medical Society:

"As for the new medical plan the trial of it will be the true test; but, at very least, it evidences a growing disposition toward social responsibility. When a responsibility is cordially and feelingly met, it is better met than when compelled by law."

### EDITOR'S NOTE: ENABLING ACTS FOR MEDICAL CARE CORPORATIONS IN OTHER STATES

During the 1939 legislative sessions bills authorizing the establishment of non-profit medical care corporations were introduced in at least eleven states in addition to Michigan and were enacted in Connecticut, Pennsylvania, and Vermont. In New York State enabling legislation was enacted for non-profit "medical expense indemnity" corporations. In this note, a brief indication of the principal provisions of the enacted laws will be given, together with citations to the unsuccessful measures.

*Connecticut:* This act, H. B. No. 857, approved June 20, 1939, permits the creation of a non-profit medical service corporation by not less than seven residents of the state and also authorizes the state medical society and eight named county societies to "jointly or severally incorporate for the purpose of operating a medical service corporation." The medical services are to be provided by registered doctors of medicine; hospital services are excluded. The consent of the insurance commissioner to incorporation is required and is conditioned on his finding that the charter is in accordance with the act and "in the public interest." Not less than $5,000 must be deposited to secure performance of obligations. The contract must contain seven prescribed provisions. Group contracts (except to families) are forbidden. Apparently the contract may provide for the payment of an indemnity as well as for furnishing services (see §4, cl. B.). The commissioner may disapprove rates found "excessive, inadequate, or discriminatory." Either party to disputes between a subscriber and the corporation may refer the dispute to the commissioner, whose decision is subject to judicial review. The property of the corporation is exempt from taxation.

*Pennsylvania:* In this state two laws, sponsored by the medical profession, were passed. The first, H. 685, amends the non-profit corporation law to provide for the creation of non-profit medical service corporations. The second act, H. 686, provides in considerable detail for the regulation of corporations created under H. 685. Supervision over these corporations is vested in the Department of Health and in the Insurance Department. They are authorized to provide medical services (as defined in the law) to persons of "low income," *i.e.*, persons without dependents having an average weekly income for the preceding 25 weeks of $30 or less; with one dependent, of $45 or less; and with more

than one dependent, of $60 or less. Doctors of medicine are to have majority control and the services provided must be obtained only from such doctors and be under medical direction and control. Free choice of physician is provided for. The corporation may define the services which it will render and require a physical examination of applicants. Applicants found in need of immediate care may be required to pay a fee therefor. No cash benefits may be paid. Authority is given to state and local officials charged with providing medical care to needy persons to provide medical services by subscribing at public expense to the corporation's service. Corporations are tax exempt. Both bills were approved June 17, 1939.

*Vermont:* This act, S. B. No. 60, approved April 14, 1939, authorizes three or more persons licensed to practice medicine to incorporate under the general corporation laws a non-profit medical service corporation to establish and operate a plan to provide medical or medical and dental services by licensed practitioners to subscribers. The corporation must obtain a permit to operate from the Commissioner of Banking and Insurance. The Commissioner may refuse the permit if he finds the rates "excessive, inadequate or unfairly discriminatory." The act prescribes certain provisions which must appear in the contract. These are derived chiefly from insurance law sources, but one such provision is a statement that the subscriber may choose any licensed physician who agrees to be governed by the corporation's by-laws concerning payment of fees. Corporations created under the act are exempt from taxation. At the end of the act is a section which confers the same privileges of incorporation on three or more persons licensed to practice dentistry, osteopathy, chiropractic, or chiropody.

*New York:* This act, N. Y. Laws 1939, c. 882, to be codified as N. Y. CONSOL. L. c. 28, art. IX-c, effective June 15, 1939, forms part of a comprehensive revision of the New York Insurance Law and combines in the same article provisions both for hospital service and for medical expense indemnity corporations. "Medical expense indemnity" is defined to consist "of reimbursement for medical care provided through duly licensed physicians, for nursing service and of furnishing necessary appliances, drugs, medicines and supplies." Discrimination in plans against legally recognized "schools of medical practice" is forbidden. The corporations may be organized under either the membership, or the cooperative, corporation law and their conversion into corporations organized for profit is prohibited. They are subject to specified provisions of general applicability in the Insurance Law. They must obtain from the superintendent of insurance permits to solicit subscribers and, after subscribers have been enrolled and have made at least one-sixth payments, licenses to do business. Licenses may be refused if, after investigation, the superintendent finds issuance to be "contrary to the interest of the people." Contracts must be for a 12-month period and contain certain specified provisions. Group contracts may be written for families, employers, and employee associations, the groups being defined by the statute. Solicitation expenses may not exceed 20% of payments received the first year, 15% the second, and 10% thereafter. Other non-benefit expenses may not exceed 20%. After the first year each corporation must begin the accumulation of a "special contingent surplus" at the rate of 2% of net premium income per year for four years and 2½% thereafter until the surplus reaches $100,000. A medical expense indemnity and a hospital service corporation may together issue "a combined contract" but neither can do so separately. Each may act as the agent of the other without license. Both types of corporations are tax exempt.

*Bills Failing of Passage:* Arkansas, S. 304; California, S. 548, A. 2494, A. 2501; Illinois, H. 977; Missouri, H. 620; Ohio, S. 104; Utah, S. 176, S. 177; Washington, S. 311, H. 199; Wisconsin, A. 401. Of these bills, all but the Illinois and Ohio bills provided for both medical and hospital services to be provided by the corporations authorized.

# THE ORGANIZATION OF CALIFORNIA PHYSICIANS' SERVICE

HARTLEY F. PEART* AND HOWARD HASSARD†

California Physicians' Service is a California non-profit corporation composed of three classes of members: administrative, professional and beneficiary. Administrative members comprise a relatively small group of physicians and others[1] in whom is vested administrative control of the corporation. The managers of the organization, that is, members of the Board of Trustees, are selected from and elected by the administrative members. Professional members are doctors of medicine practicing in California.[2] Beneficiary members are those persons who, upon payment of monthly dues, are entitled to secure, when needed, medical and surgical services from any professional member. Hospital care is not included but may be secured from any of three non-profit hospital service associations operated throughout California.

California Physicians' Service is, therefore, a vehicle available as a means of defraying the cost of medical and surgical services on a monthly or other periodic budgeting basis.[3] It has also been inaccurately described as a "voluntary health insurance scheme."

It is our purpose herein briefly to relate the story of the creation of California Physicians' Service, review the problems necessarily met and outline its operations. Our discussion is limited to a review of that which has occurred. We prefer to leave to others the complex task of determining whether California Physicians' Service or any similar undertaking is the answer in whole or in part to those social problems related to medicine.[4]

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[1] At present there are 38 administrative members of whom 30 are doctors of medicine, one is a dentist, two are members of the clergy, one is an educator, one is a newspaper publisher, and the remaining three are business men.

[2] There are approximately 5000 professional members. It is estimated that 7000 physicians are engaged in active practice in California.

[3] In fact, the sole purpose set forth in the preamble to the articles of incorporation of California Physicians' Service is the general one of spreading the cost of medical care by periodic payments on the part of a large group without injuring the standards of medical service, without disruption of the proper physician-patient relation and without profit to any intervening agency.

[4] While it is no doubt true, to paraphrase Professor Llewellyn, that "no divinity has decreed a buggy for medicine," nevertheless, there is much to be said for extensive and complete *tests* of new devices before

## PRELIMINARY CONSIDERATIONS IN PREPARING A MEDICAL SERVICE PLAN

In November, 1938, the writers were directed by their client, the California Medical Association, to aid a special committee of the Association in the preparation of a group pre-payment medical service plan. The instructions to the committee required:

1. Creation of a non-profit entity so that patients' funds would be used for their benefit only.

2. Maintenance of the professional principle of freedom of choice of physician by each patient.

3. Avoidance of special privilege to any group or favoritism to any community and, of course, discrimination against any individual or group.

4. Creation of a type of organization that would permit administrative costs to be held to the lowest possible figure consistent with efficient operation and normal growth.

5. Maintenance of control of administration and *policy* in the medical profession through its representatives.[5]

6. Adoption of the "unit system"[6] as the means of determining amounts payable to physicians and surgeons for their services.

7. Availability of the service to all California residents falling within the "restricted income groups,"[7] subject only to such requirements as might be necessary to secure a reasonable spread of risks.

8. The scope of medical service included to be as broad as possible. The only exclusions contemplated were industrial injuries and illnesses, mental disorders, chronic alcoholism, drug addiction and accidents or illness arising from lawlessness. Certain limitation for pulmonary tuberculosis, pregnancy, miscarriage and childbirth were suggested.

9. District administration (with district medical directors selected so far as possible by the profession in the locality) to be maintained in order that local conditions might be recognized and local desires adhered to wherever possible.

To develop an entity meeting each of these requirements and at the same time remain within the boundaries marked out by statutes and decisions, necessarily proved to be a considerable task. So far as we were aware, there were very few

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turning loose a legion of salesmen to supplant the "buggy" with a glittering, shiny "free for nothing—no down payment" stratosphere rocket ship. It is fondly hoped that California Physicians' Service is a better "buggy" and that the test pilots will pronounce it both safe *and* sane.

[5] With respect to this point the special committee in a bulletin dated November 26, 1938, addressed to all members of the House of Delegates of the California Medical Association, stated: "The committee, however, recognizes the interest of the beneficiaries and the public in the *funds* which will be administered and intends to safeguard such funds. . . ."

[6] The "Unit System," under the by-laws of California Physicians' Service operates as follows: At periodic intervals accumulated pooled funds are divided amongst participating physicians in accordance with the *quantity* of service rendered by each during the agreed-upon period and the sums thus distributed are accepted *as payment in full*. For example, assume that in July, 10,000 members paid a total of $17,000.00; that after deducting for administrative costs and reserves, $14,000.00 remains. Also, assume that there has been attributed to each type of medical and surgical service a certain number of "units," depending on the value of the service, and that physicians rendering services in July performed a total of 28,000 units of service. The unit of payment would then be 50c, and each physician would receive, as *payment in full* for the month of July, 50c for each unit of service rendered by him in that month.

[7] The Board of Trustees, after much discussion and inquiry, has decided upon an annual family net income of $3,000 as the maximum income permissible for full beneficiary membership benefits. This figure is, of course, subject to future revision. "Family net income" means the total earnings of all wage earners in the family unit. Persons with incomes over $3,000 per year are eligible to membership but may be charged an additional fee by any professional member asked to render services.

organizations in existence operating a pooled-fund medical service plan in which the medical profession had a voice[8] and in which the "unit system" and free choice of physician were recognized and established. Neither legislation nor direct judicial precedent existed to serve as a guide. Further, our instructions did not permit devoting the time necessary for a thorough survey of service plans of any value throughout the United States.

The first problem presented was to determine what type of organization to select. Partnerships, both general and limited,[9] business trusts,[10] and all other unincorporated organization devices were soon eliminated because of rather apparent inadequacies. This left the corporate form and, of course, our instructions forbade the use of the ordinary private corporation organized for profit.

Thus we rapidly came to the conclusion that a non-profit corporation[11] was the most feasible type of organization. Immediately, then, we were faced with two questions:

[8] On the Pacific Coast there are several plans in operation. The King County Medical Service Corporation, a Washington non-profit corporation, created by the King County Medical Society and operating in Seattle, is described in Brown, *Private American Experimentation in Meeting Medical Needs by Voluntary Action, supra,* at p. 507. The Oregon Medical Service Bureau, an Oregon corporation, operates in Portland, Oregon. It has been in existence for some time and issues a medical and hospital agreement to employed groups under which it undertakes to furnish medical and surgical services for a small monthly payment. Apparently, only physicians on the staff of the Bureau may be chosen by subscribers. Physicians are paid on a fee schedule basis. We understand, however, that recently some changes have been made in the method of operation.

The Ross-Loos group operating in Los Angeles has been highly publicized and is, perhaps, more familiar. For descriptions of the closed-staff Ross-Loos plan, see Brown, *supra* at p. 509; Note (1936) 25 CALIF. L. REV. 91, 95; Ross, *The Case of the Ross-Loos Clinic* (1935) 25 SURVEY GRAPHIC 300; (August 1939) 35 READERS DIGEST, No. 208, p. 61.

In 1937 the City and County of San Francisco by charter amendment (Cal. Stat., 1937, pp. 2790-2792) created a health service system. This is a compulsory "health insurance" plan for all municipal employees. A health service board was established, its members being elected by city employees. A pay-roll deduction is provided in an amount determined by the board. With the funds thus collected, the board is required to make available medical, surgical and hospital care to all municipal employees. The charter amendment forbids any "exclusive contract" and requires that the board offer free choice of physician and surgeon. A plan is now in operation under which all physicians in San Francisco are eligible to render medical services to city employees. Their compensation is based on the unit system, in accordance with a fee schedule adopted by the board. Hence, the patients and not the physicians set the *value* of each service.

Agricultural Workers Health and Medical Association, a California non-profit corporation, was created March 4, 1938 (Cal. Dept. of State, Corp. No. 174795), by the Farm Security Administration and the California Medical Association. It pays the cost of medical care to its members, membership being restricted to low-income farm workers. Funds are borrowed from the FSA. Any licensed doctor of medicine may render services. We are informed that no one has questioned its status under the California Insurance or Business and Professions Code.

[9] A partnership was deemed unwise because of personal liability of partners for partnership debts, power of each partner to bind the partnership by contract, breach of trust or wrongful act, and automatic dissolution of partnership on the death or bankruptcy of any partner. See CAL. CIV. CODE (Deering, 1937) §§2405-2409, 2423-2426. (Subsequent references to the California Codes will be to this edition.)

[10] Massachusetts or business trusts have many of the disadvantages of partnerships, including personal liability of the trustees for debts of the trust. Goldwater v. Oltman, 210 Cal. 408, 292 Pac. 624 (1930). In addition, they are probably taxable as corporations under the United States revenue acts. Rev. Act of 1938, § 901; TREAS. REG. 94; art. 1001-2.

[11] In 1931 California enacted a "General Non-profit Corporation Law" comprising §§593 to 605e, inclusive, of the Civil Code. §593 provides: "A non-profit corporation may be formed by any number of persons, not less than three, for any lawful purposes, such as religious, charitable, social, educational, recreational, cemetery *or for rendering services,* which do not contemplate the distribution of gains, profits or dividends to the members thereof, and for which individuals lawfully may associate themselves, . . ."

(1) Would such a corporation be unlawfully practicing medicine and surgery? and

(2) Would it be in violation of the California Insurance Code?

*(1) The Question as to Corporate Practice of Medicine*

Various phases of the problem of corporate practice of a learned profession have been before the California courts and it was, therefore, not impossible to ascertain the existing judicial attitude toward lay encroachments upon the professions.[12] It was clear that a corporation organized for profit could not employ or in any manner control a limited group of physicians and offer their services either to the general public or to "members" of the corporation.[13] However, the California Supreme Court, while holding that Pacific Health Corporation, Inc.,[14] a corporation organized for profit to its shareholders, could not lawfully select physicians for its members, took care to point out that its decision did not constitute a condemnation of non-profit corporations not offering medical services through a limited panel of physicians. The Court said:

"Our attention is called to certain data from medical and lay sources in support of the movement for group medicine and health insurance and we are told that a decision against defendant will outlaw all fraternal, religious, hospital, labor and similar benevolent organizations furnishing medical services to members. We have given careful consideration to

[12] Corporate practice of law, medicine or dentistry has been before the California courts quite frequently. The earliest cases were People v. Merchants Protective Corp., 189 Cal. 531, 209 Pac. 363 (1922), and People v. Cal. Protective Corp., 76 Cal. App. 354, 244 Pac. 1089 (1926), holding that a corporation could not legally furnish the services of an attorney at law. In Painless Parker v. Bd. of Dental Examiners, 216 Cal. 285, 14 P. (2d) 67 (1932), a corporation employing dentists who performed dental services for clients of the corporation was held unlawfully engaged in professional activities. In Masters v. Bd. of Dental Examiners, 15 Cal. App. (2d) 506, 5 P. (2d) 827 (1936), an order of the Board of Dental Examiners revoking a dentist's license was affirmed on the ground that the dentist had accepted employment by a corporation to render dental services to its "customers" and was, therefore, "aiding and abetting" unlawful practice of dentistry. In Pacific Employers Ins. Co. v. Carpenter, 10 Cal. App. (2d) 592, 52 P. (2d) 992 (1935), and Benj. Franklin Life Assur. Co. v. Mitchell, 14 Cal. App. (2d) 654, 58 P. (2d) 984 (1936), the refusal of the Insurance Commissioner to approve so-called "medical insurance" policy forms was upheld, the ground of refusal being that the policy forms disclosed on their face that the insurance companies contemplated employing a limited staff of physicians to render services to policy holders and that such conduct would constitute unlawful corporate practice of medicine and surgery. The latest California case is People *ex rel.* State Board of Medical Examiners v. Pacific Health Corp., Inc., 12 Cal. (2d) 156, 82 P. (2d) 429, 119 A.L.R. 1284 (1938). In this case, a *quo warranto* proceeding, it appeared that Pacific Health Corporation collected monthly dues from its "members" and in turn paid the cost of medical and surgical services rendered them by physicians it "selected." This was held unlawful corporate practice.

[13] In People v. Merchants Protective Corp., Masters v. Bd. of Dental Examiners, both *supra* note 12, and other cases, the facts disclosed employment of attorneys, dentists or physicians on a salary and use of their services for the benefit of members or customers of the corporation. All of these activities, of course, contemplated a profit to the corporation from the professional services rendered. In the later cases, particularly Benjamin Franklin Life Assur. Co. v. Mitchell, and People v. Pacific Health Corporation, Inc., both *supra* note 12, the corporation did not employ professional assistants on salaries or retainers but merely "selected" or "appointed" persons and paid them on a predetermined fee basis. The corporations endeavored to distinguish their activities from prior cases on the ground that their designated professional staffs were independent contractors. But the form adopted was held immaterial as long as in substance a lay entity selected professional men and secured for itself all or a portion of the fruits of professional labors.

[14] People v. Pacific Health Corporation, Inc., *supra* note 12.

this argument and we find it wholly unconvincing. . . . But it should be pointed out that the fear of applying the holding of this case to such philanthropic associations as those mentioned does not exist in the minds of the directors thereof, nor has it been suggested that the public authorities contemplate any attack on them. This illusory apprehension is expressed by defendant alone, in an attempt to bolster up its case by bringing it within the general class of associations furnishing medical or health benefits which have been tacitly approved for generations. But a most obvious and, to us, a fundamental distinction must be made between defendant and these other institutions. In nearly all of them the medical service is rendered to a limited and particular group as a result of cooperative association through membership in the fraternal or other association, or as a result of employment by some corporation which has an interest in the health of its employees. The public is not solicited to purchase the medical services *of a panel of doctors;* and the doctors are not employed or used to make *profits for stockholders.* In almost every case the institution is organized as a non-profit corporation or association. Such activities are not comparable to those of private corporations operated for profit and, since the principal evils attendant upon corporate practice of medicine spring from the conflict between the professional standards and obligations of the doctors and the profit motive of the corporation employer, it may well be concluded that the objections of policy do not apply to non-profit institutions. This view almost seems implicit in the decisions of the courts and it certainly has been the assumption of the public authorities, which have, as far as we are advised, never molested these organizations."[15] (Italics added.)

This expression of public policy led us to conclude that a non-profit membership corporation which agrees to defray the costs of medical care but does *not* undertake to restrict its members' choice of physician and surgeon, is not, in so far as California is concerned, unlawfully engaging in the practice of medicine and surgery.[16]

### *(2) The Question Whether Defraying Cost of Medical Services on Prepayment Plan is Insurance or Service*

If an organization which collects monthly or other periodic dues from its members and uses the funds thereby obtained to defray the cost to such members of medical and surgical services[17] is engaged in the business of insurance, it would be necessary

[15] 12 Cal. (2d) at 159-160; 82 P. (2d) at 430. Other cases, such as Group Health Ass'n v. Moor, 24 F. Supp. 445 (D. C. 1938), were considered but not heavily relied upon because of the thorough manner in which the California courts have covered the entire problem. For general discussions on corporate practice of medicine and whether a corporation may lawfully do so, see Notes, 73 A.L.R. 1331 (1931), 103 A.L.R. 1238 (1936), and 119 A.L.R. 1284 (1939). See also Laufer, *Ethical and Legal Restrictions on Contract and Corporate Practice of Medicine, supra* p. 516.

[16] It is significant that People v. Pacific Health Corp., *supra* note 12, was a 4-3 decision, the minority expressing the opinion that any corporation could lawfully furnish to the public the services of physicians and surgeons. *Query:* How can the dissenting opinion be reconciled with CAL. BUS. AND PROF. CODE §§2006-2008, which provide in substance that corporations and other artificial entities have no professional rights, privileges or powers? With respect to California Physicians' Service, the corporation as an entity does not "intervene" either for its own pecuniary benefit or to designate a particular physician; hence, it is submitted that no professional rights or privileges are claimed or assumed by it.

[17] Inasmuch as the furnishing of hospital care on a monthly payment basis by non-profit hospital service corporations is regulated by statute and is expressly subject to the jurisdiction of the California Insurance Commissioner and State Board of Health (CAL. INS. CODE §§11491-11517), it was decided to exclude hospitalization from consideration. This decision was reached with full realization of the fact that the language of §11495 of the Insurance Code is permissive and not mandatory so that it could well be argued that the statute does not forbid one to furnish hospital care under a pooled-fund plan through a non-profit corporation which has not complied with the Insurance Code sections.

to incorporate under appropriate insurance laws and meet all of the requirements of insurance statutes. In California, insurance companies are subjected to a 2.6% tax on gross premiums collected.[18] In addition, to incorporate as an insurer would necessitate acquisition of considerable funds as statutory reserves.[19] For these and other reasons[20] it was the opinion of the medical profession that an insurance company would be undesirable and, if possible, should be avoided.

In principle, it is clear that to defray the cost of personal services by means of periodic payments not measured by the amount of service actually rendered in the payment period, whether such services are medical, legal or other personal efforts, does not necessarily involve insurance. The question then is whether grouping individuals together and placing periodic payments in a central fund so alters the nature of the activity that what was previously service can be said to be insurance. Judicial decisions on this precise point are not numerous.[21] One of the latest cases is *Group Health Association v. Moor*[22] where the Court said:

"General definitions of the word 'insurance' throw little light. The statute does not include necessarily contracts 'to indemnify,' but is limited to those which provide for the 'payment' of indemnity. The word 'payment' as ordinarily used means the payment of money and I see no reason to think that the word is used in a different sense in the statute or that it is equivalent to 'indemnity'."[23]

It was then held that the pooling of funds to defray the cost of medical services did not constitute insurance.

*Hall D'Arth v. British Provident Assn. for Health and Additional Services*[24] is an English case in which it was held that a non-profit association formed to reimburse

[18] CAL. CONST. (Treadwell, 6th ed., 1931) art. XIII, §14; CAL. POL. CODE §3664b.

[19] If the use of pooled funds to pay medical costs is insurance, it can only be classed as "disability" insurance. CAL. INS. CODE §100. To form a mutual disability insurer without provision for assessment of policy holders, it is necessary to obtain a "guaranty fund" of not less than $250,000. *Id.* §10562. However, a disability insurer, *with provision for assessment of policy holders, in addition to the stipulated premiums,* may be created upon deposit of $25,000 with the Insurance Commissioner. *Id.* §10830. If the plan proposed contemplated payment of money to contract holders to *reimburse* for sums expended for medical and surgical services, insurance would be involved, and it would be reasonable to require at least minimum reserves. However, the use of the "unit system" removes the contingency of expenditures exceeding income and hence removes the necessity for large reserves. See note 6, *supra.*

[20] Insurance is a "business" and doctors of medicine as professional men quite naturally frowned upon classification of their services as a business enterprise. If a state bank superintendent should claim that because banks have prepared wills, all lawyers who draft wills are engaged in the banking business and are subject to his regulation, one could easily foretell the reaction of the legal profession. Further, as an insurer, California Physicians' Service would probably be unable to use the "unit system" of payment and might be required to have but one class of membership. CAL. INS. CODE §10830 *et seq.*

[21] Statutory regulations are also rare. The one statute found is in Florida, defining "sickness insurance" as any contract or agreement whereby a company, corporation or association stipulates to provide for the insured either medical attention, medicine, care during disability, or money necessary for any of such purposes. FLA. COMP. GEN. LAWS (1927) §6260. See, also State *ex rel.* Landis v. D. C. Jones Co. 108 Fla. 613, 147 So. 230 (1933). It is to be noted that the Florida statute includes both indemnity, *i.e.,* money payments, and service, *i.e.,* medical attention.

[22] 24 F. Supp. 445 (D. C. 1938). Since the writing of this article the Court of Appeals for the District of Columbia has affirmed the decision of the District Court that the Group Health Association is not subject to the District of Columbia insurance law. Jordan v. Group Health Ass'n, 7 U. S. LAW WEEK 261 (1939).

[23] Group Health Ass'n v. Moor, *supra* note 22, at 446.

[24] 48 TIMES L. R. 240, 76 SOL. JOUR. 111 (1932).

subscribers for expenses in hospitals and for the cost of surgical operations was not an insurance company and did not write insurance. The Court expressed the opinion that the association was rendering a personal service only and that insurance does not include services.

A recent California statute authorizes the State Controller upon request to deduct from the salary of any state employee necessary dues "of any non-profit membership corporation organized under the laws of this state, for the purpose of defraying the cost of medical services" and "approved by the Director of Finance."[25] The statute also authorizes payroll deductions for premiums on any "policy of group insurance." This statute may settle the entire problem, at least in so far as public employees are concerned, because courts do not interpret a legislative act in a manner that renders it meaningless or useless.[26] To avoid such a result, legislative authorization of the activities of California Physicians' Service may be inferred.[27]

There are a number of cases involving personal services other than medical or surgical services in which conflicting conclusions have been reached.[28] Without engaging in an exhaustive review, it is sufficient for our present purpose to state that after examination of many cases it was concluded that an organization which does not furnish services through physicians selected by it and which, therefore, is not an entity existing between the patient and his physician, but which allows one class of its own members to render personal services to other members and receive payment therefor from a common fund, is not engaged in the insurance business but is merely a custodian of a fund. Members who render personal services clearly are not insurers and the members receiving services are merely using group resources to pay for a personal service.

As the conclusion reached was necessarily founded upon our own deductions, we submitted to the California Medical Association two types of organization, namely, a non-profit corporation with three classes of members and a mutual disability insurance company on the stipulated premium plan with provision for assessments.[29] The House of Delegates of the Association, after consideration of all factors, decided to direct the creation of a non-profit corporation.

## CORPORATE STRUCTURE OF CALIFORNIA PHYSICIANS' SERVICE

The California Medical Association having decided to embark, for its prepayment medical service voyage, upon a non-profit membership corporation, the next step was to formulate the organization and administrative details of operation. Fortunately, California law permits great latitude in the structure of non-profit corporations. Different classes of membership with differing property, voting and other rights and privileges are permitted.[30] Restrictions on transfer of membership and

[25] Cal. Laws, 1939, c. 895.
[26] County of Los Angeles v. Graves, 210 Cal. 21, 290 Pac. 444 (1930).
[27] *Id.* at 24, 290 Pac. at 445.
[28] See notes, 63 A.L.R. 711 (1929), 100 A.L.R. 1449 (1936), and 119 A.L.R. 1241 (1939).
[29] If this type had been selected it would have been formed and operated under the California Insurance Code, §§10810-10940. See note 19, *supra*.
[30] CAL. CIV. CODE §598(9).

provisions governing forfeiture and termination of membership may be included in the by-laws.[31] Dues or assessments may differ amongst different classes of members and one or more classes may be exempt from either dues or assessments or both.[32] These and other liberal statutory provisions enabled us fully to carry out the instructions of the Association[33] within the framework of a non-profit corporation.

To proceed, we shall separately review the several parts which, taken together, comprise California Physicians' Service.

*Management and Policy:* The management of California Physicians' Service is vested in a Board of Trustees, nine in number. Trustees are elected for three-year terms by the administrative members. Administration of the Board's policies and conduct of the corporation's affairs is placed in the hands of corporate officers.[34] The power to formulate and determine policies is vested in the Board of Trustees, subject, of course, to the ultimate approval of the administrative members, who elect the trustees, and the professional members, who elect the administrative members.

*Voting Control:* To retain control of administration and policy in the medical profession, it was necessary to restrict the privilege of voting. At the same time, it was clear that it would be cumbersome to lodge voting power in the entire profession. Therefore, advantage was taken of the statutory provision authorizing different classes of membership.

The articles of incorporation provide for administrative members, professional members, and beneficiary members. Administrative members are limited to a maximum of 75. Administrative membership carries with it the privilege of voting for trustees, and upon all other matters submitted to the membership at large. The privilege of voting is expressly withheld from professional and beneficiary members, except that (1) professional members elect, by district, a portion of the administrative members and (2) matters of policy may be submitted to the beneficiary members for an advisory vote thereon.

It is not necessary that administrative members be doctors of medicine and non-medical members have been elected. Administrative membership endures for a period of three years. The state has been divided into 21 administrative districts and there are two administrative members from each district elected at three-year intervals, by the vote of the professional members practicing therein. Terms are staggered, however, so that all district representatives do not lose membership at once. In addition to the 42 district administrative members, the administrative members themselves may elect, by a two-thirds vote, additional administrative members to serve for three-year terms.

Through their power to elect administrative members, the professional members, who are doctors of medicine, have actual control of the corporation but at the same time direction of administration and policy is confined to a relatively small group.

[31] *Id.* §598(5).
[32] *Id.* §598(10).
[33] See p. 566, *supra.*
[34] The officers include a president, two vice-presidents, a secretary, a treasurer, an assistant secretary, an assistant treasurer, and a medical director.

*Free Choice of Physician:* Maintenance of the professional principle of freedom of choice was, of course, a fundamental requirement. To insure as complete a freedom of choice as possible and at the same time not interfere with administrative necessities, it was decided to create a separate class of membership, that is, professional membership. All doctors of medicine licensed to practice in California are eligible to professional membership and, if by-law qualifications are met, must be admitted thereto. The only qualifications are that the applicant hold a valid license to practice medicine and surgery and maintain in force adequate professional liability insurance. Professional members as such have no right to vote (except in district elections for administrative members) and have no proprietary interest in the assets of the corporation.[35] The articles expressly authorize one to hold both professional and administrative membership.

Upon becoming a professional member, a physician must agree to accept as compensation in full for all medical and surgical services rendered to beneficiary members such amounts as may become distributable under the unit system.[36] There is, however, no attempt to require each professional member to agree to perform services.[37]

Any beneficiary member is given the right, upon becoming entitled to receive medical or surgical services, to select as his attending physician any professional member. Inasmuch as professional membership can be acquired by any doctor of medicine as a matter of right,[38] it is possible for a beneficiary member to choose any doctor of medicine in the state and, if the doctor selected actually desires to accept the member as a patient, there is no bar to his doing so, even if he is not, at the time, a professional member of California Physicians' Service. Should the doctor fail to acquire professional membership, that failure is a voluntary election on his part to reject as patients all beneficiary members.

*Protection Afforded Respective Proprietary Interests of Professional Members and Beneficiary Members:* The several interests considered were (1) the interest of beneficiary members in funds contributed as dues,[39] (2) the interest of professional members in the same funds as the source of compensation for medical or surgical

[35] The articles of incorporation do, however, provide that if the corporation is ever dissolved, professional members are entitled to be repaid the amount of any assessments paid by them if there are sufficient assets for such purpose.

[36] Except with respect to beneficiary members having a family net income of $3,000 per year or more. See note 7, *supra.*

[37] Such an agreement would not be specifically enforceable. CAL. CIV. CODE §3390. Hence, if included, it could not be enforced except by expulsion from professional membership on proof of refusal to accept a beneficiary member as a patient. Such action would seriously impair the fundamental principle that *all* doctors of medicine may be a part of California Physicians' Service.

[38] Under the by-laws, the Board of Trustees cannot refuse an applicant qualified as stated above, who tenders the necessary registration fee.

[39] It is apparent that an enterprise that collects funds from members to defray the cost of unpredictable medical and surgical needs may, like an insurance company or a bank, be considered "clothed with a public interest," and, with respect to its administration of such funds, a "public trustee." If so, then California Physicians' Service is subject to the control of the California Attorney General. CAL. CIV. CODE §605c (supervision by Attorney General of any non-profit corporation holding property subject to any public trust).

services rendered, and (3) the interest of professional members in funds raised by direct or indirect assessment upon them.

Considering the third interest first, it was found necessary to provide organization funds, to require a registration fee for election to professional membership. It is not contemplated that the fees paid by professional members shall be returned to them. Instead, it is intended to retain the registration fee fund as "working capital." However, if dissolution should ever become necessary, the articles of incorporation provide that "after payment, satisfaction and discharge of all claims and demands against, and liabilities of the corporation, . . ." there shall be distributed "to the professional members a sum equal to all assessments paid by them, and if the assets and property remaining are insufficient for a return in full to each professional member of all assessments, a *pro rata* distribution shall be made." Hence, the claim of professional members with respect to funds contributed by way of assessments is recognized.

To insure that dues of beneficiary members will be used solely for services which are of benefit to them, the by-laws restrict the use of corporation funds to payments of necessary administrative costs and payments to professional members for medical and surgical services rendered. No unrelated activities are permitted. In fact, no diversion of income from strictly medical matters is within the power of the corporate management. In addition, the articles require that in the event of dissolution there shall first be returned to the beneficiary members current dues, and then, after return to professional members of assessments paid, any remaining assets "shall be paid over and distributed to the beneficiary members in proportion to the amount of dues contributed by each thereof."

Undoubtedly, the most effective protection afforded beneficiary members is the unit system of payment for medical and surgical services. The unit system serves as an automatic check upon overpayment for professional services and insures that no deficit can occur. If physicians were paid for professional services upon a fee schedule expressed in terms of dollars it is conceivable that the cost of services rendered could for a considerable period exceed income, deplete the treasury and necessitate assessment of beneficiary members, large increase in dues or termination of the entire plan. These possibilities, all undesirable, are not possible under a system in which professional members accept as payment in full their *pro rata* share of income actually received during the preceding monthly or quarterly period.

*Reserves:* After payment of administration costs, current income will chiefly be used to pay professional members for services rendered. As the corporation's legal *liability* for the cost of future medical services is limited, under the unit system, to future income, there is no need for accumulation of large surplus funds. As the service progresses, it is, however, contemplated that the board of trustees will exercise the authority granted to it in the by-laws to set apart each month a portion of the monthly income as a reserve fund, and thus build against unforeseeable contingencies. During each monthly period current income will then be expended as follows: payment of current administration and acquisition costs, allocation of a portion of in-

come to a reserve fund, and division of the remainder amongst professional members for professional services rendered.

Reserve funds may only be invested in investments authorized by California law for investment of funds of savings banks.[40] After a sufficient reserve is established, the by-laws require that any excess funds must be used to extend the service to beneficiary members or to reduce the cost thereof to them.

*Method Adopted to Solve Problem Occasioned by Lack of Applicable Actuarial Experience:* Except for the experience of the King County Medical Service Corporation,[41] there is little information available to aid one to compute the amount per member per month needed to meet fully the costs of medical service in a free choice of physician plan. The problem is further complicated by the fact that the exact cost per member per month, where a fairly large group is covered, of each particular kind of medical or surgical service is likewise not precisely ascertainable.

To avoid possibility of an excess of medical expense over income available for medical costs, the unit system of payment for medical services was chosen. As previously explained,[42] the unit system involves a periodic *pro rata* distribution of available funds in full satisfaction of claims for services rendered during the preceding accounting period. Any reasonable time interval may be chosen as the accounting period, *e.g.*, each calendar month or each quarter. As a consequence of the unit system, if the monthly dues prove inadequate to meet all costs, California Physicians' Service will not be in the position of an insurance company that has under-estimated the amount of premium income necessary to cover its outstanding risks. It will, of course, in such event, be necessary either to reduce the medical benefits of beneficiary membership or increase monthly dues.

In addition to adopting the unit system, California Physicians' Service has determined, at least during its early development, to restrict eligibility for beneficiary membership to persons affiliated with some *bona fide* group of five or more. Employed groups are preferred, but any other group not created solely for the purpose of securing medical services may be acceptable. Aside from the matter of distribution of risks, one purpose of this requirement is to reduce collection costs to a minimum, thereby lessening the risk of inadequate income.

*Supervision of Professional Services:* It is essential in any plan involving payment for medical care to large groups from a common fund, to keep informed concerning and, if necessary, supervise the performance of professional services and hospital care in order to safeguard the fund against unnecessary expense. To meet this problem the by-laws of California Physicians' Service provide for a Medical Director and for Deputy Medical Directors in 21 administrative districts. The Medical Director and his deputies are chosen by the Board of Trustees, but only after consultation with professional members in each district concerned. It is thus possible to select in each

[40] For authorized investments, see CAL. CIV. CODE §574, and, generally, CAL. GEN. LAWS act 652, §61.

[41] See, for a description of the King County Service, Brown, *Private American Experimentation in Meeting Medical Needs by Voluntary Action, supra* at p. 511.

[42] See note 6, *supra*.

district a Deputy Medical Director in whom the medical profession therein has confidence.

Rules and regulations have been adopted requiring each professional member to secure authorization from the Deputy Medical Director in his district before hospitalizing a beneficiary member, undertaking major surgery or any long, unusual or expensive course of treatment. One of the rules provides that professional members must report to their District Deputy Medical Director before referring beneficiary members for x-ray examination or treatment or special clinical laboratory investigation. In emergency cases, the physician may, of course, proceed to hospitalize or undertake surgery at once and report later.

A determined effort has been made by the medical profession to formulate rules and regulations that will prevent unnecessary or ill-advised treatment or hospitalization yet will not operate in a manner that may unduly hamper physicians or interfere with their judgment in caring for patients.[43] It is desired not to disturb the personal and confidential physician-patient relation any more than is essential for proper administration of members' funds and acquisition of factual data for actuarial studies.

To provide actuarial statistics, case reports and other information deemed essential by the consulting actuary of California Physicians' Service are required.

*Membership Certificate Forms, Contracts and Agreements: Medical Benefits Included:* As there are three classes of membership, each with different duties, rights and privileges, it was necessary to provide a written evidence of membership for each class, setting forth the particular duties, rights and privileges of membership in the class concerned. Following the California non-profit corporation law, certificates of membership were adopted for issuance to each member.[44] With respect to administrative membership, the certificate is brief and merely recites that California Physicians' Service is a non-profit corporation, that administrative membership is not transferable[45] and that the person designated on the certificate is entitled to the rights and privileges of administrative membership.

In the certificate of professional membership greater detail was found desirable. Such certificates provide that during existence of membership the member has the privilege of receiving compensation from "available funds of California Physicians' Service" for medical and surgical services rendered to any beneficiary member in good standing who may need and request such services. Professional membership is not transferable voluntarily or by operation of law and the certificate so states. It is also provided that acceptance of the certificate completes an agreement by the pro-

[43] The rules were prepared by leading physicians with extended experience in group medical plans.

[44] CAL. CIV. CODE §604, provides: "A non-profit corporation shall not issue shares of stock, but membership in such corporation may be evidenced by certificates. . . ."

[45] The California non-profit corporation law permits non-transferable membership and allows by-law provisions terminating membership and all of its incidents on death of the member or at a specified time. See, CAL. CIV. CODE §§598, 602. The articles and by-laws of California Physicians' Service prohibit the transfer of membership of any class and terminate membership on death or on the happening of certain other conditions, *e.g.*, failure to pay dues or assessments, etc.

fessional member that he will look solely to the funds of California Physicians' Service for compensation for such medical or surgical services rendered to any beneficiary member as are included within the benefits of beneficiary membership.

Shortly after California Physicians' Service was incorporated, an application for professional membership was sent to all doctors of medicine practicing in California. The application form adopted contains representations by the applicant that (1) he is legally licensed to practice medicine in California, (2) he agrees to be bound by the articles of incorporation, by-laws, schedules of compensation for professional services and their unit systems and rules and regulations of California Physicians' Service, and (3) he agrees to carry malpractice insurance in designated amounts while a professional member.

With respect to beneficiary membership, it was early decided that California Physicians' Service should have authority to issue several different service agreements having different benefits and different dues rates. It was also decided that sound development of the plan required restriction of beneficiary membership to persons affiliated in groups so that an adequate spread could be obtained and an inexpensive and convenient means of collecting monthly dues would be available.

To contract with groups, such as employee associations, labor unions, and others, it was found desirable to adopt not only individual beneficiary membership certificates but also master contract forms to cover the various arrangements necessary to be made with the group itself. In addition, to be able to offer different benefits and monthly dues, it was necessary to devise some means whereby the duties and privileges of beneficiary membership could be made flexible. Fortunately, California law authorizes non-profit corporations, through appropriate by-law provisions, to levy dues "upon all classes of membership alike, or in different amounts or proportions or upon a different basis upon different classes of membership."[46] Further, "membership of one or more classes may be made exempt from either dues or assessments or both."[47]

Accordingly, the by-laws provide that the Board of Trustees may create several divisions of beneficiary membership and that the dues of each division may differ. At the present time there are two divisions. Under one division, beneficiary membership includes all medical and surgical services found necessary as a consequence of illness or injury, with the following limitations:

(a) Maximum length of treatment of one year for any one illness or injury;

(b) A waiting period of twelve months for hernias, tonsilectomies, and adenoid and nasal septum operations; and

(c) A waiting period of twenty-four months for pregnancy, miscarriage or childbirth.

In addition the following are excluded:

1. All conditions existing at time of acquisition of membership;
2. Chronic alcoholism, drug addiction, mental disorders;
3. Injuries or illness for which care or treatment is provided under any workmen's compensation or employers' liability law;

[46] CAL. CIV. CODE §598(10). [47] *Ibid.*

4. Injuries arising out of lawlessness or intentionally self-inflicted; and
5. Dental services.

The second division of beneficiary membership presently established is identical to the first division, except that the cost of the first two ordinary visits to any professional member for any one illness or injury must be paid by the beneficiary member. Such payment is made directly to the professional member. Monthly dues are, of course, less than for membership in the first division.

Further divisions can be created from time to time if different coverages are found desirable and if particular classes of persons should be included; for example, if governmental care for indigent or low income workers should be entrusted to California Physicians' Service.[48]

In order to have definite and uniform arrangement with various groups acquiring beneficiary membership, master "medical service agreements" have been adopted. The agreements contemplate two parties, *viz.*, California Physicians' Service and the agency representing prospective beneficiary members. The medical and surgical services included and those excluded or qualified are set forth in detail in the master agreement.

In those instances in which the contracting party is an employer, a clause providing for a pay roll deduction is included. If the contracting party is not an employer, a clause providing that the group shall be "responsible for" the collection of monthly dues is substituted.

In addition, the "medical service agreements" provide that:

1. Hospital care is not within the benefits of membership in California Physicians' Service;
2. Each member of the group or agency who becomes a beneficiary member of California Physicians' Service thereby agrees to be bound by its articles, by-laws and rules and regulations;
3. Beneficiary membership is not transferable voluntarily or by operation of law;
4. California Physicians' Service is not responsible for negligence or other wrongful acts on the part of its professional members;
5. The Medical Director of California Physicians' Service or any physician whom he may designate, may, pursuant to rules and regulations of California Physicians' Service "decide whether the physical condition of any member requires treatment, and, if so, what treatment";
6. Professional members are subrogated to the rights of beneficiary members in the event of an existing right to recover or recovery of the cost of medical care from any third party;
7. Beneficiary membership shall endure during the life of the agreement except that if an employee-member ceases to be affiliated with the contracting group he may maintain beneficiary membership for a maximum period of six months thereafter;
8. The entire agreement may be cancelled on ninety days' notice by either party and, if cancelled, all beneficiary memberships issued thereunder likewise terminate;
9. There is a grace period for payment of beneficiary membership dues and at the expiration of the grace period all right to benefits ceases; and

[48] See p. 582, *infra.*

10. All disputes between members, beneficiary or professional, or between a member and California Physicians' Service, must be submitted to arbitration.

Upon execution of a medical service agreement with any group or organization, each member of the group is then presented with an application for beneficiary membership. Upon completing the application, an individual certificate of beneficiary membership is issued to the new member. The master agreement is not distributed to each person in the group and, therefore, the certificate of beneficiary membership contains a full statement of the medical and surgical services excluded or qualified. In addition, the certificate has attached to it printed instructions so that each beneficiary member may know what steps to pursue in the event of illness or injury.[49] In order that each beneficiary member may know whether his own physician is a professional member, a list of such members is furnished each contracting group.

*Monthly Dues:* At present, dues for the first division of beneficiary membership (full coverage) are $1.70 per month. Dues for the second division (under which the member pays the cost of first two professional visits) are $1.20 per month. If the member holds a hospital contract, he pays an additional 80 cents per month which is collected at the same time as his California Physicians' Service dues, thus making total monthly payments of $2.50 or $2.00.

*Selection of Risk and Distribution of Loss:* We have previously pointed out that beneficiary membership is restricted to groups having some method available for collection of monthly dues. This, of course, eliminates individual self-selected risks who are, usually, in immediate need of medical care. Dependents are also excluded, unless they are members of a contracting group, because of unfortunate experiences elsewhere with this type of risk.[50] Another check upon beneficiary membership

[49] The instructions read as follows: "IN THE EVENT OF NEED FOR MEDICAL SERVICES:

1) Secure from your employer an identification form which he will fill out.

2) You may choose any doctor who is a Professional Member of California Physicians' Service. A list of members is on file with your employer. Select your doctor as you would if you were paying him yourself. You are not restricted in any way so long as the doctor is a Professional Member of California Physicians' Service. The doctors, however, have the same freedom in selecting patients as you have in selecting doctors.

3) If your doctor determines that you need hospital care, use the hospital service contract you hold.

4) You are entitled to all necessary medical and surgical services for diagnosis and treatment, except for: [Here follows the list of the coverage exceptions and of the service subject to a waiting period set forth on pp. 577-578, *supra.*]

6) As long as you remain a Beneficiary Member you are entitled to necessary medical and surgical services up to a maximum of one year for each illness or injury.

7) Before undertaking special diagnostic matters or special treatments your physician must, by the terms of his Professional Membership agreement with California Physicians' Service, secure authorization of the Medical Director.

8) In the event you leave the service of your present employer, you are entitled to service during the month for which you have paid dues. However, by continuing to pay your dues in advance, you may maintain your Beneficiary Membership, entitled to all the benefits thereof, for a period of six months. This temporary extension of coverage may make it possible for you to maintain continuous protection if you return to your present employment or secure other employment in a group holding a contract with California Physicians' Service.

9) If the net annual income of a Beneficiary Member exceeds $3,000.00 the attending Professional Member may, by the terms of the contract of membership, charge a fee in excess of the sum paid to him by California Physicians' Service."

[50] Dependents are also self-selected risks and, hence, costly. The San Francisco Health Service System

which is expected to enable California Physicians' Service to avoid the difficulties involved in selection of risks, is the exclusion from medical and surgical care of pre-existing conditions.

To secure a reasonable distribution of loss, California Physicians' Service has determined not to accept groups of less than ten unless all members of the group acquire beneficiary membership and to accept groups over ten only if a substantial (40-70%) number of the group apply and secure membership.

Whether the precautions discussed are sufficient or, on the other hand, too conservative, only time and experience can prove.

*Hospitalization Benefits:* As previously stated, hospital care is not included within the benefits of beneficiary membership in California Physicians' Service. Several considerations led to the omission of hospitalization. First, and most important, there are, in California, three non-profit hospital service corporations, each furnishing hospital care to subscribers for a small monthly payment.[51] As these organizations were founded and are now operated through the joint efforts of medical societies and the hospitals in the state, it was immediately decided to work in harmony with them and leave entirely to them the field of hospital care on a periodic payment plan. Another consideration, although not controlling, was the Insurance Code chapter authorizing non-profit hospital service corporations to submit to regulation and supervision of the Insurance Commissioner.[52] While it may reasonably be contended that hospital care, like medical care, is primarily a personal service and hence not within the category of insurance, nevertheless, in view of the services offered by non-profit hospital service corporations, it was thought not necessary to rely or act upon this proposition.

Realizing that the average person who desires to budget his sickness and injury costs will want to obtain, if possible, protection against both medical and hospital expenses, California Physicians' Service and the hospital service corporation have an arrangement under which groups may acquire at the same time and for the same period, both beneficiary membership in California Physicians' Service and hospitalization contracts. Under this arrangement the combined monthly payment consisting of membership dues in California Physicians' Service and contract payments to a hospital association are paid to one agency representing all four organizations. The agency then allocates to each organization the amount payable to it. In this manner an individual may secure both medical and hospital protection through one monthly payment. In such instances each member's medical and surgical benefits are evidenced by a certificate of beneficiary membership in California Physicians' Service and by a master medical service agreement with his group, while his hospitalization

(see note 8, *supra*) which includes dependents of municipal employees, has appeared to prove this fact. "Unit" payments to physicians have been much less than "par" for several consecutive months, and we are informed that professional services to self-selected dependents has been a major factor in the forced reduction of the value of the unit.

[51] The hospital service corporations are: Insurance Association of Approved Hospitals, Associated Hospital Service of Southern California, and Intercoast Hospitalization Insurance Association.

[52] CAL. INS. CODE, div. 2, pt. 2, c. 11A. See, also, discussion in note 17, *supra*.

benefits are evidenced by a hospitalization contract issued to him by one of the three hospital service corporations. The hospital service contracts of the hospital associations and the medical service agreements of California Physicians' Service have been prepared with this procedure in mind and accordingly the two supplement each other and avoid conflict or duplication in benefits offered.

*Problem of Liability for Professional Torts (Malpractice):* In California, actions against physicians for alleged negligence in diagnosis, treatment or care of a patient have become entirely too common[53] to permit light treatment of the subject of physicians' liability or "malpractice" insurance in connection with any pooled-fund medical service plan.

Several possible liabilities had to be considered, namely, responsibility of each professional member for his own acts, responsibility of the Medical Director and his deputies and advisors for their acts in performing their duties as expressed in the rules and regulations,[54] liability of California Physicians' Service, if any, for negligence of its professional members and its liability for negligence of its employees and agents including the Medical Director, his deputies and advisors.

The liability of professional members to beneficiary members for negligence in professional matters was met by (a) requiring all professional members to maintain in force professional liability insurance and (b) including an arbitration clause in all medical service agreements under which all claims and disputes between professional and beneficiary members must be submitted to arbitration by an independent arbitrator whose award is final and binding.[55] With respect to the Medical Director, deputy directors and advisors selected by California Physicians' Service, it is essential that complete insurance protection be maintained at all times covering each individual and California Physicians' Service for any liability that may be imposed upon it under the doctrine of *respondeat superior*.

Whether the funds of California Physicians' Service may be in jeopardy each time a service is performed by a professional member is an unanswered question. On principle it seems clear that, except for procedures performed or omitted under instructions of the Medical Director or one of his deputies, each professional member is acting independently so that he alone is responsible to his patient. However, to guard against a contrary opinion, the medical service agreements contain a clause expressly providing that California Physicians' Service is not answerable for the negligence of any professional member.[56] In view of the fact that the funds of the

[53] A series of decisions applying the maxim *res ipsa loquitur* in malpractice cases apparently stimulated malpractice litigation. Early in 1939 the California Supreme Court reversed its trend and refused to apply *res ipsa loquitur* to a case involving severance of a nerve during surgery. Engelking v. Carlson, 97 Cal. Dec. 364, 88 P. (2d) 695 (1939).

[54] See note 43, *supra*.

[55] In California, an arbitration clause is valid and specifically enforceable. CAL. CODE CIV. PROC. §§1280-1286; Pacific Orient Co. v. Superior Court, 203 Cal. 797, 262 Pac. 1117 (1928). Neither party can ignore the clause and maintain an action upon a matter which, under the clause, should have been arbitrated. Clogston v. Schiff-Lang Co., 2 Cal. (2d) 414, 41 P. (2d) 555 (1935); Note (1929) 17 CALIF. L. REV. 643.

[56] The clause provides "C.P.S. acts only as agent of its professional members and assumes no liability for the breach of any one or all of the obligations undertaken by its professional members. In no case is C.P.S. an insurer against the negligence of its professional members. . . ."

Service may be said beneficially to belong to all beneficiary and professional members, so that their depletion to benefit one member would to that extent injure all others, there would appear to be no public policy contravened by the clause.

Two other precautions have been taken to protect California Physicians' Service. First, the arbitration clause previously mentioned, which should effectively discourage groundless actions filed for their nuisance value, and, second, insurance coverage.

*Extension of Beneficiary Membership to Lowest Income Groups:* Clearly, those persons now eligible to medical care at public expense[57] are not concerned with a group prepayment medical care plan. There are also many persons with restricted incomes, either because of low wages or periodic intervals of enforced idleness, who may feel that they cannot afford health protection at their expense. It is possible that governmental subsidization of this group's medical costs (already accomplished in some communities) may become widespread.

If there is further extension of government subsidized medical care, some vehicle for rendering such service is necessary. For this reason the articles and by-laws of California Physicians' Service provide that the corporation has power to contract "for the performance of medical services by its professional members or for the furnishing of hospital care or both . . . or for any other lawful object or purpose, with any public or municipal corporation, body politic, the State of California or any political subdivision of said State," or any administrative agency of the state or the United States of America, or "any corporation incorporated under the laws of the United States or any foreign state."

Under this power, California Physicians' Service is ready and able to undertake the same type of service that a number of non-profit corporations created by the Farm Security Administration render to needy farm groups and migrant workers. From the viewpoint of the taxpayer and the public it would seem unanswerable that an organization representing the entire medical profession is more likely to use public funds in an economical and efficient manner, subject, of course, to normal supervision, than any government agency untrained in the problems of the profession.

## CONCLUSION

We have endeavored to picture California Physicians' Service so that there may be an understanding of what it is and how it functions. If, as a consequence of this brief article, any light is cast upon the problem of payment for medical care that measures up to American standards and *demands* with respect to quality, then, its purpose has been more than fulfilled.

[57] In many California counties not only indigent residents but also residents with average incomes are, according to our information, admitted to the county hospital. These people are called "part-pay" patients, and generally are required to pay that portion of the county's cost for their care and attention that their resources or incomes warrant.

# THE MEDICAL CARE PROGRAM FOR FARM SECURITY ADMINISTRATION BORROWERS

R. C. WILLIAMS*

The program under which more than 100,000 low-income farm families, borrowers from the Farm Security Administration, are at present obtaining medical care grew out of an economic necessity. It has appeared as an incidental by-product of a depression-born program of farm loans which were made exclusively to families unable to obtain credit from any non-governmental source. It is designed to accommodate a very special economic group only. It is governmental only in that its organization is sponsored and its operations partly financed—through loans to its debtor families to enable participation—by a governmental credit agency which has loaned several hundred million dollars with little security except the character and productive ability of families receiving medical aid under the arrangements.

Its background explains much of its organization and method.

## I

Five years ago, three million farm families were on the brink of disaster. Flood and drought had played havoc with crops. The depression brought economic chaos to an already unstable farm economy. Crops were selling at low prices, credit had vanished. It was a period of foreclosures and "penny" auctions. The wholesale migration of farm families from one farm area to another seeking an opportunity for livelihood became a common phenomenon. For roughly one fourth of the farm population, relief was the only means of living until the Farm Security Administration offered to make small loans to enable farmers to continue planting their crops.

The Farm Security Administration makes these loans, repayable within 5 years at 3 percent, so that farmers may buy the feed, seed and tools necessary for the year's operations. Often, the loans must help the farmer to meet the expenses of clothing and feeding his family until he makes a crop.

Before a farmer can receive a loan he fulfills the following requirements:

1. He must be unable to obtain either funds or satisfactory credit from any other source, public or private.

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2. He must know how to run a farm or have derived the major part of his income for the previous six months from farming operations.

3. He must be approved for the loan by a local county committee, generally composed of two or three farmers and one or two business men who can attest character and ability.

4. He must be able to do the farm work.

5. He must be renting a farm or have an equity in a farm.

All loans are based on adequate guidance of the family during the period in which they are trying to re-establish themselves. The purpose of loans and guidance is to make the families again self-supporting and self-reliant. The major factors given emphasis in undertaking to aid the rehabilitation of a family are: suitable land tenure, adequate equipment, adjustment of any over-burdening previous debts, sound planning of farm and home management, use of community and cooperative services to supplement family equipment, adequate financing at reasonable rates of interest, careful budgeting and record keeping. Farm Security Administration supervisors work with the farmer until the loan is repaid, helping him to plan his farm enterprise and advising him on more effective methods of raising crops or conserving the soil. Home management supervisors periodically visit the farm-wives and advise them on their problems of canning, raising garden produce, sewing and other work of the homemaker involving the success of the family enterprise.

## II

It was through these county supervisors, who are constantly in touch with borrower families, that the first inklings of a serious gap in the program's early efforts were called to the attention of administrators. Difficulty in working with some of the families was traced to lack of medical attention—to acute illness, abscessed teeth, hernias, malaria and other conditions. It was reported that loans were defaulted as chickens, hogs, or calves were sold to pay for medical bills. When families had no money to pay for physicians' services, avoidable deaths occurred and the Government lost the money it had invested.

A director of the rehabilitation program in a western state reported,

> "As to need for medical assistance for our rehabilitation families, I believe I can safely state that 75% of our families on this program have been placed in their present position by some form of illness in the family and the resulting crippling effect of doctor and hospital bills. Practically every financial statement shows a liability of from $100 to $3,000 now owing to doctors, hospitals, or both. In my opinion, the 'missing link' in our rehabilitation program in this state is a satisfactory approach to this very vital question of health of our families and excessive medical costs."

An investigation of a sample of Farm Security Administration borrowers who had failed revealed that 50 percent of the "failure" cases were directly traceable to "bad health." Aside from the wanton waste of human life and curtailment of borrowers' usefulness to themselves, some kind of medical care program was plainly indicated to the Farm Security Administration from a purely economic point of view, as a credit agency, by the findings of this survey.

The basis of the medical care program is a conviction that a family in good health is a better credit risk than a family in bad health. Economic security depends, to a large extent, on health security. The Farm Security Administration loan program was in jeopardy until some feasible plan for getting medical aid for its farmers could be found.

## III

Once the need was recognized, the next step was to get medical aid to needy borrower families who could not obtain it through regular channels. There was no organized system of providing medical care for medically indigent rural families in most of the states. In a few states, the families had to be certified as paupers before any medical aid was given. In one state, a "Black List" of patients who had not paid their doctor bills prevented physicians from attending indigent cases on pain of expulsion from the local medical society. Nothing could be done for these families without the help and understanding of the medical profession. The gap between the families needing medical attention and the physicians who could render it was not simple to bridge.

Due to the cost and delay involved in making a loan, and the additional difficulties of auditing and individually justifying expenditures for medical care by borrowers, it was not feasible for the Farm Security Administration to make small supplemental loans to its borrowers to help them meet medical care bills as they were presented. A single loan to each family at the beginning of the year to cover medical care for the twelve months was indicated. Even this, however, was precarious. The incidence of disease among individuals is not exactly predictable; and it was certain that in some instances where serious illness developed, any probable sum set aside would be inadequate to cover costs for the family stricken; either the bill would go unpaid or the family would be bankrupted, the loan advanced by the Farm Security Administration defaulted, and the work of rehabilitation left to begin again. In other instances the sum loaned for medical care would be too much. In order to avoid the occasional family financial disasters and the defaulting of medical care bills which the loans were intended to forestall, it seemed necessary to persuade borrowers to pool the funds loaned to each for medical care at the beginning of the year, so as to give each family assurance of all needed care as well as to keep medical costs within their ability to pay. Finally it was necessary that physicians, assured that each of these near-relief families was paying according to its ability into the pool, should accept as payment for services that proportion of their regular fees which funds in the pool would cover.

When a medical care program was started in 1936 in Arkansas, North Dakota and South Dakota, however, the principle of prepayment for medical services had not yet been accepted by the medical profession. And while insurance for protection against loss of life, threat of fire or theft were old stories to the American public, the banding together of a group of people for mutual protection against the incidence of illness was new to the public and viewed with misgivings.

The families which had borrowed from Farm Security Administration had learned the rudimentary lessons of cooperation for their everyday needs by buying plows, livestock for breeding purposes, or canning equipment in groups for the use of all participants. This form of cooperation, however, showed immediate results in the use of the purchased article. Paying a flat sum for medical care was somewhat of a risk. You might be sick this year, and then again, you might not. It was a higher type of cooperation that these families would have to accept voluntarily.

On the other hand, two facts argued the feasibility of the plan: the fact that these farm families realized they had desperate need for such a service and wanted one, and the fact that physicians—especially rural physicians—were anxious to re-adjust a system of compensation which left them after a period of years with thousands of dollars worth of unpaid bills on hand.

The only feasible approach to the problem, at any rate, seemed to be the grouping of families under a plan, paying a flat fee per year for medical care, and the participation of physicians who would agree to treat these families at a uniform fee schedule which would take into account the families' low income.

State medical associations were approached with tentative outlines for medical care plans. The plans were framed so that existing local facilities would be used in every case and that participation fees would be based on the ability of the family to pay—a principle long recognized by the American Medical Association and put into practice by the medical profession. Not all state medical associations have yet been approached—the present program started only in the spring of 1937—but already 26 state medical associations have approved medical care plans.

In some states, the medical association welcomed the opportunity of trying out an experiment which was obviously necessary and which they had long wondered about. Other state medical associations accepted the plan on sufferance with the understanding that it was purely on a trial basis. At a recent meeting of the House of Delegates of the American Medical Association, a resolution stating general approval of the action of the procedure of state associations cooperating in guiding the organization of such plans was passed without dissenting voice.[1]

## IV

A great variety of plans has been initiated, but, in general, they follow three patterns. In most of the plans, borrower families pool their funds and put them in charge of a trustee.[2] The trustee then pays all physicians' bills for the group as fully

[1] A publication from the Bureau of Medical Economics of the American Medical Association states, "Medical societies are warranted in studying these plans with the same sympathetic attitude that they have toward any other persons who need medical care. The actual operation of any specific Farm Security Administration plans will, of course, depend on acceptance by the practicing physicians in each community in which the program is proposed. These physicians may properly look to state and county medical societies for an expression of acceptance or rejection of the principles involved." ORGANIZED PAYMENTS FOR MEDICAL SERVICES (1939) 89.

[2] When a family borrowing from the Farm Security Administration lacks funds at the beginning of the year to make the payment into the fund, the Farm Security Administration will increase the amount

as funds will allow, on a monthly, *pro rata* basis. Under another plan which is gradually being discontinued, funds for each family are placed in the hands of a trustee, but separate accounts are kept for each family. The third kind of plan provides that an association of Farm Security families—grouped together on projects—may employ one or more physicians on a salary basis to provide necessary medical aid.

The basic procedure in each case, however, is the same although state and county differences are apparent in most plans. Before any medical care plan is set up, county supervisors—the people who are directly in contact with the families—are asked if there is a need for a medical program revealed in the current farm and home plans of the family. If there is a need and the families desire to participate, representatives of the Farm Security Administration charged with the responsibility of carrying out the program draw up a tentative medical care plan. A common understanding of the benefits that should be included and a reasonable family fee, based on income indicated in the farm and home plans, is reached before the matter is laid before the state medical association by representatives of the Farm Security Administration.

A meeting with the economic committee or council of the state medical association usually follows at which a memorandum of understanding or a guide to be used as a basis for developing local Health Service Associations within the state is drawn up. These memoranda of understanding are prepared by the officials of the state medical associations, with the assistance of officials of the Farm Security Administration. The usual policy of the state association has been to refer the memorandum back to its house of delegates for final endorsement. In some states, simple resolutions were adopted by the house of delegates referring this matter back to the local medical societies to be worked out, without specific recommendations. Based on these memoranda or resolutions, agreements are then worked out with local medical societies.

The agreements with the county societies recognize the three basic principles of the medical program: (1) the participation fee for borrower families is based on their ability to pay as determined by their farm plans; (2) there is free choice of physicians who agree to participate; (3) funds are set aside in the hands of a bonded trustee at the *beginning* of the operating period.

The medical benefits covered in the plan usually include: (a) ordinary medical care, including examination, diagnosis and treatment in the home or in the office of the physician; (b) emergency surgery necessary to save the life or limb of the individual as determined by the physician in charge of the case; (c) emergency hospitalization believed necessary and recommended by the attending physician; (d) obstetric care, including pre-natal, and post-natal, services; (e) ordinary drugs dispensed or prescribed by attending physician; (f) dentistry prescribed by the attending physician and believed necessary to relieve acute systemic diseases or relieve pain.

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of the general loan for rehabilitation by the sum necessary to permit participation. No separate loan for medical purposes is made; participation in the medical care program is regarded as quite as necessary to sound farming as is adequate workstock, and no distinction between moneys for the two purposes is made in either the loaning or collection processes.

V

For these services the family under the most typical agreement usually pays from $15 to $30 a year. The amount paid varies according to benefits included under the plan, according to size of average farm incomes in the locality, and according to size of family. A typical payment schedule for physician's care in a low-income county might be an annual $18 for a man and wife with an additional $1 for each child up to eight with a maximum payment of $26 per family. The money is pooled and a certain amount is allocated for hospitalization and emergency needs, including surgical care, at the beginning of each period. The remaining fund is then divided into equal monthly allotments for the period covered.

Physicians submit monthly statements based on a fixed fee schedule to the trustee for services rendered. These bills are reviewed by a committee from the local medical society. If the total bills for a given month exceed the amount available, all bills are proportionately reduced and each physician paid his pro rata share of the month's allotment. If the allotted funds for the month are sufficient, the bills are paid in full; if a balance remains, it is carried forward to the next month or to the end of the period, and then used to complete paying bills for months in which funds were not adequate.

The pool plans vary as to organization. While under many of the county pool medical care plans the farmer-participants are formally organized into unincorporated associations, others are informal groups with the trustee responsible for funds and the reviewing committee of physicians responsible for checking the bills.

Benefits included under the medical care plans also vary according to the participation fee and local needs. The percentage of money set aside from the total funds for hospitalization, drugs and physicians' services are worked out with the local county medical societies. The majority of county pool plans cover emergency medical care, including obstetrics, and hospitalization. Forward looking counties have also added dental services, while a few plans provide only for emergency medical care. In one state, 40 counties have plans for dental care which are operated on a separate basis. For $3.50 a year for each family and $.50 in addition for each person in the family, the participating family obtains emergency treatment, simple fillings, extractions, prophylaxis and cleaning.

Drugs are sometimes a problem under the plans. Unless druggists cooperate[3] with the program, it is found that an unusually high percentage of the funds—sometimes as much as 35%—must go to pay the standard price of drugs; from 7% to 12% is more nearly normal. In a number of the plans, however, physicians dispense the drugs they prescribe or have the prescriptions charged to themselves. The ideal solution, of course, would be to have the borrower families pay for the drugs they need independently of the plan. It was found, however, that because these families have such a low cash income, they were not in a position to pay for drugs and often the families could not have the physician's prescription filled.

[3] By accepting pro-ration of bills along with physicians or giving a fixed reduction.

In all county pool plans, there is a set fee schedule for the physicians serving the families. The individual contract plan works on an entirely different basis. Funds for each family participating are set aside and the physician of the family's choice agrees to render medical service for a certain sum a year. If the family has no illness that year, the money is refunded or applied to the next year's account. If the family needs more services than are covered by the fee they have paid, the physician continues his services free of charge during the remainder of the period.[4]

## VI

Experiences with the two plans clearly indicate that for low-income families the first plan is preferable, that is, a plan providing for pooling of the individual fees into one general fund. In Ohio and Missouri, where the individual contract plan is in effect, results have not been wholly satisfactory and the plan may be dropped within a few months. The plan is hard on the physician when a protracted illness develops and too often, families will not see the physician in order to save the money they have set aside for medical purposes.[5] Nor does the plan distribute the cost over many families, so that the cost of severe illness to one family can be more nearly equalized. In Missouri, the Economics Committee of the State Medical Association has agreed to try out a medical care plan on a pool basis in a few counties to study its merits.

County or district plans for medical care are operating in 23 counties in Alabama, 68 in Arkansas, 2 in Colorado, 5 in Florida, 108 in Georgia, 5 in Indiana, 2 in Idaho, 5 in Iowa, 25 in Kansas, 7 in Louisiana, 41 in Mississippi, 12 in Missouri, 1 in New Jersey, 7 in New Mexico, 10 in North Carolina, 11 in Ohio, 12 in Oklahoma, 17 in South Carolina, 7 in Tennessee, 18 in Texas, 1 in Utah, and 8 in Virginia.[6] The swift extension of the program during the last two years is indicated by the increase in the number of county plans operating in Georgia where there were 5 counties participating last year and 108 counties this year.

Agreements with the state medical associations prior to approaching county medical societies have been reached with Wisconsin, Wyoming, Kentucky, Pennsylvania, New Hampshire, West Virginia, Vermont, New York, and Washington.

## VII

There is a somewhat different approach to the problem of medical care in homestead projects established by the Farm Security Administration. In most of these communities, from 100 to 200 families have settled on adjoining farms. When these projects are located some distance from cities, the problem of medical care for the

[4] The Farm Security Administration through its local supervisors keeps in touch with the working of the plans where they are set up, but has no authority over them—loans are to the individuals to enable participation, not to the group or association organized to obtain medical aid.

[5] A collateral function of the prepayment feature of the plans is that of encouraging acceptance of preventive medicine by the participants. Too often low-income families in the past have habitually waited until illness became serious to the point of debilitation of the patient before obtaining medical aid.

[6] These figures were taken from a statement prepared as of June 30, 1939. Since that date, additional counties have been added to the program in several of these states.

homesteaders is often an acute one. In a few instances, they have employed a physician living nearby on a part-time basis. Occasionally, it has been necessary to attract a resident physician to the project, by setting up a program providing a basic guaranteed income. In most cases, however, the services of all nearby physicians are utilized. Medical care programs have been organized on 30 projects, and programs are now being set up on eight other projects.

In several communities the homesteaders have themselves organized voluntary beneficial associations which have worked out special agreements with physicians and hospitals. In some instances the families pay regular membership dues in cash, without help from the Farm Security Administration. In certain other projects the Administration loans money to the homesteaders for this purpose, and these loans are later repaid when the crops are sold. A wide variety of arrangements for medical care are in effect in these community projects.

A few facts regarding a typical project program will illustrate how the medical care needs of the homesteaders are being met. Every one of the 141 families on this project became a member of the health association, paying in advance $18 per family for general practitioner care for one year. All five physicians living nearby participated, agreeing upon a uniform fee schedule which represented a moderate reduction in their usual fees. An average of 83.5% payment was made on medical bills throughout the first year, the monthly payments ranging from 64.5% to 100%. Of the families in the association, 96% had one or more of their members receiving service during the year, and 47% of the families received service for which the charges exceeded the $18 membership fee.

## VIII

Distinct from the general program of medical care is the program set up in North and South Dakota and in California and Arizona. These four states had local problems necessitating a completely different type of plan. North and South Dakota had been seriously affected by the drought; California and Arizona experienced an influx of migrants living in highly unsanitary conditions who were a potential threat to the health of nearby communities.

North and South Dakota first tried a medical care program in 1936. In these two states alone, about 55,000 families were participating in a state-wide medical plan by November 1, 1938. By paying $2 a month per family for a minimum period of six months, families became members of the North Dakota Farmers' Mutual Aid Corporation or the South Dakota Farmers' Aid Corporation. Through these corporations they were entitled to emergency medical care, emergency dental care, emergency hospitalization, prescribed drugs and home nursing. The family had the free choice of any physician licensed to practice medicine in the state. The charges made for medical service were based on a special schedule of fees agreed to by participating physicians and other professions concerned. Bills were paid monthly and prorated if funds did not cover the full amount of the bills.

With the advent of the more general program of medical care and the experience

gained from it, certain flaws were noted in the Dakota plans. Both families and physicians seemed discontented—the families maintaining that they did not receive enough services, the physicians stating that they did not receive adequate compensation for services rendered. In South Dakota, there was the additional factor that practitioners other than legally qualified doctors of medicine were seeking to participate in the plan.

The uncertainty of whether funds necessary to continue the program would be appropriated by Congress caused additional uneasiness about the plans. The program was declared inoperative as of July 1, 1939, pending reorganization.

At present, North Dakota has no medical care plan, but an outline of proposed action has been drawn up. It includes a payment of $33 per family a year to include emergency medical and dental care as well as emergency hospitalization and prescribed drugs. A higher fee was set to avoid the past experience of having insufficient funds.

A further change proposed was that the medical care program be set up on a unit basis, utilizing one or more counties as local conditions seemed to indicate, and that funds paid into the plan by the families residing in a given area be kept separate for that area, thus leaving in the hands of the families and professional groups in the district virtual control of the plan. In effect, the proposal as it stands would put into operation in North Dakota local medical care plans similar to those existing in other states. The actual operation of the plan is pending its acceptance by the physicians of the state.

In South Dakota, a district plan is being set up on a trial basis at Pierre. This unit will provide medical care for Farm Security Administration families in the seven counties in that area. There is a potential case load in this area of approximately 2,500 families or 12,500 persons, with 13 physicians, 8 dentists, and 2 hospitals. Funds will be loaned to these families for participation on the basis of $33 a year per family, which will provide emergency medical and dental care, hospitalization and prescribed drugs.

The unit was set up in order to test the legality of a ruling recently issued in South Dakota. At a recent session of the South Dakota legislature, a bill was enacted which purports to require that all practitioners of the healing art participate in any public health and medical care program that is conducted in South Dakota. The bill might compel the South Dakota Farmers' Aid Corporation to utilize the services of osteopaths, chiropractors, and other similar practitioners, and thus alienate the medical profession from the program. The Attorney General of South Dakota has given a written opinion to the effect that this act applies only to funds appropriated by the State of South Dakota. The matter cannot be finally decided until it is passed upon by the proper courts.

In order to pave the way for such action, the single medical care unit was set up at Pierre. Should the osteopaths and chiropractors wish to make a test case of the matter, they may seek an injunction and the matter will be finally determined by

the courts. No further units will be established in South Dakota until this legal question has been settled. The decision will affect approximately 22,000 families in South Dakota who are receiving aid from the Farm Security Administration.

## IX

In California and Arizona, a different type of medical care program was undertaken, to meet the needs of migratory agricultural workers who required medical attention, but rarely could afford to pay for such aid. The influx of migrants into California and Arizona since 1935 has created a serious public health problem in these two states. Most of them have a low and uncertain income, live in roadside "jungles," patched tents or hastily-improvised shelters with no sanitary facilities.

The constant movement of migrants from one farming area to another, sometimes more than 300 miles away, contributed to the rapid spread of communicable diseases. Despite the vigilance of the California State Department of Health, outbreaks of smallpox or typhoid in widely separated counties remain a potential threat.

In May, 1938, the Farm Security Administration, with the cooperation of the California Medical Association, the State Department of Health, and the State Relief Administration, formed the Agricultural Workers' Health and Medical Association, incorporated under state laws. Each agency has a representative on the Board of Directors of this non-profit corporation.

Migrants make applications for medical treatment at the association's district offices or camp treatment centers. A certificate of membership in the health association, which serves as an identification card, is issued to the applicant. He then selects his physician from a list of participating physicians or is treated by the local part-time physician in charge of the treatment center. The Agricultural Workers' Health and Medical Association is billed for the medical services or hospital services rendered. In many treatment centers, local physicians work in the clinics at designated hours on alternate days. The personnel of the typical treatment centers consists of a part-time physician, a nurse, and a clerk. Services include ordinary medical and surgical care, laboratory examinations, X-ray, dentistry, prescriptions, and required treatment.

Although the migrant-workers are obligated to repay the cost of service "if so requested," their economic status precludes any expectation of repayments in most cases. Some workers, however, have been able to repay a few dollars. In view of the savings effected in the health of the two states under this program, it seems probable that adequate financial support will continue. Similar conditions prevailed in Arizona, and similar measures were undertaken.

There are at present 13 medical care centers in California and 6 in Arizona.

## X

Appraisal of the medical care program is difficult. There are many pitfalls that have been avoided, and yet there are bound to be difficulties in a program which affects so many people in widely diverse areas. The human element cannot be over-

looked. No matter how perfect a plan is theoretically, when put into practice it must deal with actualities. There has been a certain amount of abuse of the program by both the physicians and the families. Physicians will sometimes present bills for previous services to these families, or for services to families not on the program, or charge a higher fee for rehabilitation borrowers than for other people on the same economic level. Families sometimes use a number of physicians during the month, will request service for chronic ailments, or request unnecessary services. These difficulties were to be expected and mechanisms have been set up to control them.

Each participating physician gets a list of participating Farm Security families in his county and each family on the program gets a list of cooperating physicians. The health participation agreement which the family signs sets forth the medical benefits to which they are entitled. Physicians keep individual records of each family visited. In some areas, participating families make monthly reports on health services they receive. In addition to this, a reviewing committee, drawn from the physicians' ranks, is set up under each plan to go over bills. This committee can adjust bills when necessary. A strong reviewing committee limits abuses by the physicians. The county supervisor acts in a like capacity for the families, checking on the number of unusual demands for service made by families. Usually, if the family is abusing the program the matter can be adjusted satisfactorily, otherwise the family is dropped from the program.

The attitude of both the physicians and families towards the medical care program is, on the whole, favorable. In an Arkansas county which has had a medical care plan operating for three years, families were asked whether they did not object to paying $20 to $30 into the medical fund when a doctor might not be called all year. The replies were invariably something like this: "I'm pleased about it. I hope I just go along paying that money and I hope no doctor ever crosses the step. Just knowing I can get a doctor when I need one suits me." Many of these families feel that the plan is like "burial insurance."

A physician serving these people stated that no country physician ever got more than 40% of his bills paid. At present, this physician is getting 100% payment on his bills. Not all physicians participating in the program manage to get such a high percentage of repayment, but a county supervisor reports, "The participating physicians are well pleased." Monthly payments to physicians have ranged from 40 to 100%. Payments under the plans average the country over, 65% of total bills presented. One physician remarked that he was glad to get that much of his collection, since in other cases he had not collected that much. From another county in a southern state comes the report, "The doctors would like a 100% payment, but they admit that 74% is better payment than they usually collect from their rural practice. Some doctors have admitted that they were opposed to the project until they served on reviewing committees or otherwise saw more of the aim of the program."

The heart of the program lies in a clear understanding on the part of physicians and families as to what can be expected under the program and its limitations. It is

essentially a special program for an under-privileged group of farm people. The program could not be transferred to any other segment of the population without some change. A more solvent group of people would demand an extended and fuller program of medical care. But, for the group of people for whom the program is giving new opportunities and aid in efforts to get back on their feet, the plan is a boon. Since it is impossible to isolate the results of the medical care program from concurrent Farm Security Administration programs of diet improvement, environmental sanitation, and better housing, it is impossible to state statistically the results of the program in terms of generally improved health.

In the final analysis, the fact that 99% of the medical plans in operation last year are continuing to operate is a telling point, since the whole basis of the medical care plans is *voluntary* cooperation from families and physicians.

# THE ANTI-TRUST PROSECUTION AGAINST THE AMERICAN MEDICAL ASSOCIATION

BENJAMIN D. RAUB, JR.*

Early in the year 1937 Group Health Association, Inc., was organized under the laws of the District of Columbia[1] as a non-profit cooperative organization for the purpose of "arranging for the provision of medical care and hospitalization to its members and their dependents on a risk-sharing prepayment basis."[2] This association (hereafter referred to as GHA) was organized voluntarily by, and membership was originally limited to, employees of Home Owners' Loan Corporation.

Despite beliefs to the contrary, the only connection between the federal government and GHA was a grant of $40,000 by HOLC, made because it was felt that GHA would reduce the loss of employees' services through illness. There was some discussion in Congress of the propriety of this grant,[3] but no action was taken concerning it. Subsequently, GHA members voted to include as eligible for membership all civilian employees of the executive branch of the government, a limitation imposed by GHA's charter. Since this extension ended the close association which had existed between GHA and HOLC, GHA members later voted to assess themselves to create a fund for repayment of the HOLC grant.

Upon the organization of GHA, The Medical Society of the District of Columbia, an affiliate[4] of the American Medical Association (hereafter referred to as AMA) initiated a policy of opposition to GHA. The legality of GHA was questioned in suits brought by the Insurance Commissioner of the District of Columbia on the ground that GHA was engaged in the insurance business, and by the United States District Attorney on the ground that GHA was a corporation engaged in the practice of medicine. The court held that GHA was engaged in neither insurance nor the practice of medicine.[5]

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[1] D. C. CODE (1930) c. 5, tit. 5.

[2] Indictment, §33. For the text of the indictment, see 111 J. Am. Med. Ass'n 2495 (Dec. 31, 1938); *N. Y. Times*, Dec. 28, 1938, p. 20.

[3] 83 CONG. REC. 3620, 3881, 4240, 4256, 4333, 4566, 4658, 5792, 6162, App. 676 (1938); H. R. RES. Nos. 452, 473, 475, 476, 75th Cong., 3d Sess. (1938).

[4] The term "affiliate" will be used, although the terminology adopted by AMA for societies associated with it is "component" for a local society and "constituent" for a state society.

[5] Group Health Ass'n, Inc. v. Moor, 24 F. Supp. 445 (D. C. 1938). The District Attorney did not appeal from this decision. The Court of Appeals for the District of Columbia decided in favor of GHA in

The most important result of the strife between GHA and organized medicine has been the prosecution by the government of AMA and two of its affiliates, The Medical Society of the District of Columbia and Harris County Medical Society, of Texas, together with certain individual defendants,[6] for violation of Section 3 of the Sherman Act.[7] This section declares it a misdemeanor to "engage in any . . . combination or conspiracy . . . in restraint of trade in . . . the District of Columbia."

The medical societies and the other defendants demurred to the indictment. The purpose of a demurrer is to enable the court to decide, before trial of a criminal case, whether, if the facts as stated by the government are assumed to be true,[7a] the action of the defendants was in violation of the law. If the demurrer in a criminal case is sustained, the indictment is quashed and a new indictment, based on other facts, must be obtained, if the prosecution is to be renewed. If the demurrer is overruled and the defendant then pleads "not guilty," the trial of the case follows. The government must then prove beyond a reasonable doubt sufficient of the facts alleged in the indictment to sustain a conviction.

Judge Proctor of the District Court of the District of Columbia decided in favor of the defendants, sustaining the demurrer.[8] The government has taken an appeal from this decision to the Court of Appeals for the District of Columbia and has petitioned the Supreme Court of the United States for a writ of certiorari which, if granted, would permit appeal directly to the Supreme Court.[8a] Inasmuch as these proceedings are pending, the scope of this article will be to outline impartially the questions of law raised by the demurrer, the arguments advanced by each side in support of its views, and the disposition of these questions by the District Court in its decision.

The indictment, a document of considerable length, makes allegations which may be summarized as follows:

GHA was established as an experiment in group medical practice on a risk-sharing, prepayment basis.[9] The defendant societies, being opposed to GHA, conspired (1) to restrain GHA in its business of arranging for the provision of medical care and hospitalization to its members and their dependents, (2) to restrain GHA members in obtaining, by cooperative efforts, adequate medical care for themselves and their dependents from doctors engaged in group medical practice, (3) to restrain doctors serving on the medical staff of GHA, (4) to restrain other doctors in the District of Columbia in the pursuit of their callings, and (5) to restrain the Washington hospitals in the operation of their businesses.[10]

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an appeal taken by the Insurance Commissioner. Jordan v. Group Health Ass'n, Inc., 7 U. S. LAW WEEK 261. This decision was subsequent to the decision on the demurrer in the principal case.

[6] These defendants include officials of AMA and of The Medical Society of the District of Columbia. Among them are Drs. Morris Fishbein and Olin West.

[7] 26 STAT. 209 (1890).

[7a] In a demurrer, those facts which are well pleaded in the indictment are accepted as true by the demurring party, but only for the purpose of deciding the questions of law raised by the demurrer.

[8] 28 F. Supp. 752 (D. C. 1939).

[8a] This petition has since been denied. 7 U. S. LAW WEEK 417 (Oct. 24, 1939).

[9] Indictment, §14.

[10] *Id.*, §34.

The defendants were able to accomplish these ends by means of the by-laws of The Medical Society of the District of Columbia and the "Principles of Medical Ethics" promulgated by AMA, and by means of the power which AMA and its affiliates exercise in the medical profession and the hospitals of the United States. The Medical Society of the District of Columbia brought expulsion proceedings against several member doctors associating themselves with GHA, as having violated the "Principles of Medical Ethics." The charge against Harris County Medical Society was based upon a similar proceeding. It was also charged that The Medical Society of the District of Columbia, by means of a "white list" of approved organizations, groups, and individuals, from which GHA was omitted, circulated among members of the medical society, threatened with disciplinary action any members who should become associated with GHA or who should consult with members of its staff.[11]

AMA and its affiliates exercise considerable power over the hospitals of the United States because AMA or its affiliates can prevent members from making use of the facilities of a hospital unapproved by AMA and thus deprive the hospital of its staff. AMA can also deprive such a hospital of the valuable services of interns, since internship at an unapproved institution is almost worthless.[12] Thus, by circulating a "white list," from which GHA was omitted, among the hospitals of Washington, the defendants "urged and demanded that the Washington hospitals admit to their staffs only those doctors who were members" of societies affiliated with AMA, "well knowing that doctors on the medical staff of Group Health Association, Inc., were not permitted, and intending that they be not permitted, to become or remain members of such societies,"[13] although they "were and are qualified, ethical practitioners."[14]

The defendants attacked the sufficiency of the indictment on three main grounds: (1) The indictment was not formally sufficient to maintain a prosecution under the Sherman Act. (2) The indictment failed to show that the conduct of the defendants was an unreasonable restraint of trade within Section 3 of the Sherman Act. (3) The practice of medicine, being a profession, does not come within the meaning of "trade" as used in Section 3 of the Sherman Act.

*Was the Indictment Formally Sufficient?*

The defendants pointed out at the beginning of their argument that since the Sherman Act is a criminal statute, the defendants should not be subjected to its penalties unless the conduct complained of was clearly within its provisions.[15] They complained that the indictment was so vague and indefinite that they could not ascertain the exact nature of the charge against them; that after naming the individual defendants, the indictment failed to refer to them again, even in the charging part; that the indictment failed to make nineteen allegations of vital importance to the charge, such as that the means employed in the alleged restraint of trade were illegal, or that GHA or any of the hospitals suffered damage by reason of the alleged restraint.[16]

The government replied that in the indictment it had alleged the facts of entrance into the conspiracy with as much particularity as possible, despite the fact that an indictment under the Sherman Act charging merely that the defendants "engaged in

[11] *Id.*, §36(a).
[12] *Id.*, §36(b).
[13] *Id.*, §29.
[14] *Id.*, §36(a).
[15] Def. Brief, 2, citing U. S. v. Trans-Missouri Freight Ass'n, 58 Fed. 58, 77 (C. C. A. 8th, 1893).
[16] Def. Brief, 54-59.

a conspiracy" in restraint of trade and commerce had been upheld.[17] The indictment informed the defendants of the terms of the agreement which they are charged with adopting, to hinder GHA in obtaining qualified doctors and hospital facilities, and to hinder GHA doctors from obtaining consultations or treating and operating on their patients in Washington hospitals.[18]

Judge Proctor in his opinion agreed[19] with the defendants that "the indictment is afflicted with vague and uncertain statements. In some instances material facts are altogether lacking." He was further inclined to believe that the defendants would be injured "by the prejudice likely to arise by an indictment which smacks so much of a highly-colored, argumentative discourse against them,"[20] inasmuch as the indictment accompanies the jury when it begins its deliberations.

*Were the Restraints Charged Illegal?*

The defendants further objected to the indictment's failure to charge "either by allegation or factual recital, that the restraint was either direct or unreasonable."[21] Since the establishment of the "rule of reason" in *United States v. Standard Oil Co.*[22] it is necessary, to make a case under the Sherman Act, to show a conspiracy in unreasonable restraint of trade. They argued that a labor union, lawfully organized and in lawful pursuit of the purposes of the organization, may not be held to violate the anti-trust act because of incidental restraint on trade or commerce arising from the union's policies, and that the defendants were in an analogous position.[23]

The government contended that the medical associations could not classify themselves as labor unions. While both are voluntary membership associations, the chief purpose of labor unions is to engage in collective bargaining. Medical societies, however, do not engage in collective bargaining, but indeed oppose any attempts to interfere with the individual doctor-patient relation, and so are in no way similar to labor unions.[24] The defendants' reply to this was that they were not claiming to be labor unions, but that they were drawing an *analogy* to labor unions.[25]

The defendants insisted that when it is doubtful whether the acts of an association of persons constitute a violation of the Sherman Act, the court must examine into the means used to determine whether they are illegal; that here the means were clearly legal and that, therefore, the indictment could not stand.[26] There is no question that physicians may lawfully organize into societies, pass by-laws for the governance thereof, and exercise the power of expulsion or other disciplinary action to enforce such rules.[27] There is no allegation that discipline was not exercised in accordance with the rules and regulations of the Society. If the defendants exercised

[17] U. S. v. New Departure Mfg. Co., 204 Fed. 107 (W.D. N. Y. 1913).
[18] Indictment, §36.
[19] 28 F. Supp. at 757. It is not entirely clear that the decision is rested upon the formal inadequacy of the indictment, although the language of the court is sufficiently pointed for it to have done so.
[20] 28 F. Supp. at 757.
[21] Def. Brief, 40.
[22] 221 U. S. 1 (1910).
[23] Def. Brief, 38.
[24] Gov. Brief, 40.
[25] Def. Brief, 36.
[26] *Id.* 10, citing Truax v. Corrigan, 257 U. S. 312 (1921), and U. S. v. Patterson, 55 Fed. 605 (C. C. D. Mass. 1893).
[27] Def. Brief, 3-4.

their discipline as a matter of right, then the exercise of their right could not have been illegal.

To this argument the government replied that the indictment does not charge that the defendant societies were unlawful or that they could not legally adopt or enforce valid by-laws. The gist of the action lies, not in the means employed, but in the *combining* and *conspiring*.[28] While the means employed by the defendants may have been lawful, not even otherwise lawful means may be adopted for the effectuation of an unlawful conspiracy.[29] In this case the defendants did not institute proceedings against the doctors on the staff of GHA "merely in the ordinary, routine enforcement of the constitution and by-laws of defendant, The Medical Society of the District of Columbia. Rather, the proceedings were undertaken as an integral part of the concerted attempt to suppress Group Health Association."[30]

The defendants argued that the use of a "white list" was lawful, as a means of informing the members of the association of those deemed unfair by the association.[31] They insisted that the use of the "white list" sent to the hospitals was also legal, since it was "not only the right, but the *duty* of organizations having rules which may adversely affect another in their operations, to appropriately warn others, in advance, so that resulting injury may be avoided if possible."[32]

The government, on the other hand, asserted that the type of conspiracy which employs a blacklist is "illegal *per se*."[33] In support of its contention it cited *Eastern States Lumber Dealers' Ass'n v. U. S.*[34] In that case a group of lumber dealers combined among themselves to boycott any wholesale dealer who attempted to sell retail, and circulated information as to such dealers by means of an "Official Report." The court held that while an individual retailer had an absolute right to refuse to trade with a wholesaler competing with him, the effect of the combination was to cause retailers who had no personal grievance against the competing wholesaler to refuse to trade with him, and the combination was therefore "within the prohibited class of undue and unreasonable restraints."[35] Thus, the government analogized AMA and its affiliates to associations of businessmen, while the defendants analogized themselves to labor unions.

The government also urged that the demand by defendants that the Washington hospitals admit only AMA doctors to their staffs constituted a secondary boycott on GHA. It defined a secondary boycott as one in which "a group of persons bent on destroying another, combine not merely to refrain from dealing with him themselves, but also to coerce third persons into withdrawing or withholding patronage from him, such coercive pressure being exerted by boycott and threats of boycott upon those third persons."[36] It asserted that this type of boycott is invariably condemned

[28] Gov. Brief, 37.
[29] *Id.* 38, citing Aikens v. Wisconsin, 195 U. S. 194, 206 (1904), and Hitchman Coal & Coke Co. v. Mitchell, 245 U. S. 229, 253 (1917).
[30] Gov. Brief, 23.
[31] Def. Brief, 6-7, citing American Federation of Labor v. Buck Stove and Range Co., 33 App. D. C. 83, 123 (1909), and other cases.
[32] Def. Brief, 8.
[33] Gov. Brief, 51.
[34] 234 U. S. 600 (1914).
[35] Gov. Brief, 59-60.
[36] *Id.* 52.

by the courts, citing several cases, all of which involved the imposition of a secondary boycott on an employer by a labor union.[37]

The defendants contended that an examination of *American Federation of Labor v. Buck Stove Co.*[38] would disclose that unlawful means must be employed to constitute coercion and establish unreasonable restraint of trade by means of a secondary boycott, while the means employed by defendants were legal. Even so, they said, under the theory of the indictment, GHA and defendants were competitors, and since the hospitals constituted only a "common arena of employment" for GHA and defendants, the case more closely resembled the attempts of rival unions to obtain sole recognition in a plant.[39]

The government further offered the case of *Montague & Co. v. Lowry*[40] as a situation parallel to the refusal of the defendant societies to permit GHA doctors to become or remain members or to obtain consultations with member doctors. In that case, the dominant manufacturers and dealers in the tile industry combined in an association, the by-laws of which provided that no member should purchase tiles from a nonmember manufacturer or sell tiles to a nonmember dealer except at greatly advanced prices. The court upheld the right of a nonmember to damages under the Sherman Act, saying that the obvious purpose of the association was to restrain commerce in order to retain the entire business for the members of the association, that nonmembership was followed by grave results, and that no persons in the business could be put under legal obligation to become members in order to enable them to transact their business. "In other words, Montague & Co. v. Lowry holds it to be an unreasonable restraint of trade and illegal as a violation of the Sherman Act for a group of persons so to combine and conspire as to make their sanction a condition precedent to the economic existence of a competitor."[41]

In support of the charge that the defendants had conspired to restrain doctors not on the staff of GHA, the government cited *Anderson v. Shipowners' Association,*[42] which held that the combination of shipowners into an association fixing the requirements for qualification as seamen on their vessels was an unreasonable restraint of trade and commerce within the Sherman Act, since "each of the shipowners and operators, by entering into this combination, has, in respect of the employment of seamen, surrendered himself completely to the control of the association."[43] The doctors of AMA, it was argued, have similarly surrendered to AMA their freedom of action and decision in the practice of their profession.[44]

In opposition to these authorities, the defendants cited *Anderson v. United States.*[45] There certain livestock traders combined to establish rules for the conduct of their business and agreed to refuse to trade with other than member traders. The court held that the purpose of the refusal to trade with other than members was to

[37] Loewe v. Lawlor, 208 U. S. 274 (1908); Duplex Co. v. Deering, 254 U. S. 443 (1921); Bedford Cut Stone Co. v. Journeymen Stone Cutters' Ass'n, 274 U. S. 37 (1927).

[38] *Supra* note 31.

[39] Def. Brief, 36.

[40] 193 U. S. 38 (1904).

[41] Gov. Brief, 75.

[42] 272 U. S. 359 (1926).

[43] 272 U. S. at 362.

[44] Gov. Brief, 84.

[45] 171 U. S. 604 (1898).

compel all traders to join the association, and that there was no unreasonable restraint of trade within the Sherman Act.

The government distinguished *Anderson v. United States* on the ground that the court decided that the alleged restraint did not operate in interstate commerce, and further, that there had been no intention to restrain. In addition, it was asserted that the Supreme Court has failed to cite the case "in affirmative support of any principle for twenty years, and whenever during that period the case has been cited to it, the Court has either explained, distinguished, or ignored it."[46] The defendants vigorously disputed this contention, submitting numerous cases within the past twenty years in support of their position that the *Anderson* case has been followed and is still good law.[47]

The court, in its opinion, did not deal with the foregoing questions, doubtless feeling that it was unnecessary to do so, since its decision on the point which follows was sufficient for the determination of the case.

*Did the Defendants' Activities Restrain "Trade"?*

The main force of the defendants' attack on the indictment was directed to the proposition put forth by the government: that the practice of medicine is "trade" within the meaning of Section 3 of the Sherman Act. The government's argument was based upon the difference in meaning between the phrase "trade and commerce" in Section 1 (which had been held to mean solely "commerce" since it was necessarily limited by the bounds of "interstate commerce" under the interstate commerce clause)[48] and the same phrase in Section 3, which applies to the District of Columbia, where Congress has full police power. Thus, the phrase in Section 3 has a wider scope of meaning, and cases holding that "certain kinds of activities do not constitute interstate commerce within the protection of Section 1 are not authorities governing decision as to what types of activities constitute trade within the meaning and protection of Section 3."[49]

The Supreme Court, in *Atlantic Cleaners and Dyers, Inc. v. United States*,[50] held that the application of Section 3 to a particular combination and conspiracy depended on this test: could Congress legislate against the particular combination? If so, Section 3 is to be construed as applying to it,[51] since "Congress meant to deal comprehensively and effectively with the evils resulting from contracts, combinations and conspiracies in restraint of trade and to that end exercised all the power it possessed."[52]

The government argued that the Sherman Act "does not legislate against kinds of people," but "against kinds of activity. . . . It was with the economic evils that flow from a kind of conduct that Congress was seeking to deal—not with the character or training of the person restrained."[53] It indicated that Congress at the time of the passage of the Sherman Act was not wholly unaware that there might be

[46] Gov. Brief, 89-90.
[47] Def. Brief, App. "B" (p. 64).
[48] CONSTITUTION, Art. 1, §8, cl. 3.
[49] Gov. Brief, 94.
[50] 286 U. S. 427 (1932).
[51] Gov. Brief, 102.
[52] 286 U. S. at 435.
[53] Gov. Brief, 99.

professional combinations or contracts of a restraining nature, and that Section 3 might extend to such acts.[54] Dictionary definitions were submitted, defining the word "trade," in its broader sense, as an occupation or means of livelihood. However, the government to prove its claim that the practice of medicine is a "trade," relied principally on the English case of *Brighton College v. Marriott*,[55] wherein "trade" is defined as the habitual supplying, as a matter of contract, of money's worth for full money payment.

Adopting another point of attack, the government called attention to the rule of statutory construction that "when a statute uses a word or phrase which has a definite and familiar meaning at common law, the legislature will ordinarily be assumed to have adopted the common-law meaning of the word or phrase," a rule "of special importance in construing statutes that are declarative of the common law."[56] In enacting the Sherman Act Congress adopted the policy of the common law against contracts and combinations in restraint of trade. Congress, however, provided that such contracts, combinations and conspiracies should not only be unenforceable, as at common law, but could be enjoined, or made the basis for a private civil action or a criminal prosecution for a misdemeanor. The conduct prohibited is the same as at common law.

"The Federal courts," the government pointed out, "have repeatedly held, in both civil and criminal cases, that the Sherman Act adopts, and its terms are to be defined in the light of, the common law restraint of trade cases."[57] It then pointed out numerous cases at common law, involving English and 32 American jurisdictions, where agreements restraining members of the medical profession were treated as restraints of trade, subject to the same rules and exceptions recognized in all cases of contracts in restraint of trade.[58]

To clinch the matter, the government cited *Pratt v. British Medical Association*,[59] as factually on all fours with the principal case, but differing legally in that it was a common law action for damages brought by the doctor whose practice had been restrained. The court found that the action of the defendant had been a "cruel" boycott of the plaintiff, in unlawful restraint of trade; that the association's threat to boycott any member who consulted with the plaintiff was the use of coercion, which, incapable of being justified by honesty or disinterestedness of motive, certainly could not be justified by advancement of defendant's own interests; that the corporate power of the association to "maintain the honour and interests of the medical profession" did not give the association a blanket power to decide that those doctors of whom it disapproved were not entitled to practice medicine, and that in any event, the plaintiff had not violated the "honour and interests" of the profession.

[54] 21 CONG. REC. 2726 (1890).

[55] [1925] 1 K. B. 312, 316.

[56] Gov. Brief, 118.

[57] *Id.* 120, citing Addyston Pipe & Steel Co. v. U. S., 85 Fed. 271, 279 (C. C. A. 6th, 1898), and Standard Oil Co. v. U. S., 221 U. S., 1, 59 (1911).

[58] Gov. Brief, 138-174.

[59] [1919] 1 K. B. 244.

In response to these arguments, the defendants pointed out that the ordinary meaning of the word "trade" is commerce or occupations, distinctly apart from the liberal arts, the professions, and agriculture.[60] They cited the language of Justice Story in *The Schooner Nymph*[61] quoted in the *Atlantic Cleaners* case:[62] "We constantly speak of the art, mystery, or trade of a housewright, a shipwright, a tailor, a blacksmith, and a shoemaker, though some of these may be, and sometimes are, carried on without buying or selling goods." This, the defendants asserted, was the broad meaning of the word "trade," and, since it did not embrace the practice of a profession such as medicine, the acts of the defendants could not be regarded as restraining "trade." They quoted from *Federal Trade Commission v. Raladam Co.:* "Medical practitioners . . . follow a profession and not a trade,"[63] and from *Graves v. Minnesota:* "employments or trades . . . manifestly involve very different considerations from those relating to such professions as dentistry."[64] In view of these expressions of the Supreme Court, the defendants concluded that it would be impossible to adopt the government's broad "money's worth" definition of "trade."

The government sought to distinguish the language of Justice Story on the grounds that it was used in defining "trade" as employed in the Coasting and Fishery Act of 1793 and would not be so limited in other contexts; that it was not an enumerative definition, but merely illustrative; and that the quotation of this language by the court in the *Atlantic Cleaners* case was only for purposes of adopting a definition broad enough to determine the question then before the court.[65] The answer to the quotation from the *Raladam* case was that the statement in that case was directed to the point that the practice of medicine is not interstate commerce and, therefore, is not entitled to protection from unfair methods of competition by the Federal Trade Commission. It was merely dictum, to be read in its context.[66] As for the *Graves* case, it merely recognized "that the peculiar public interest in the practice of dentistry justifies state legislatures in imposing regulations on that practice that perhaps could not be imposed on some other occupations."[67]

The defendants asserted that the cases involving covenants in restraint of the practice of medicine between members of the profession did not decide the question whether the practice of medicine is a "trade," but merely extended to the medical practitioner the same protection which is accorded to one engaged in trade and which is known in the common law as the rules against restraint of trade.[68] They distinguished the *Pratt* case because: (1) it was a civil action submitted on the theory of private rights, not as a criminal conspiracy; and (2) one of the issues was as to the legality of the rules of the British Medical Association, whereas here the legality of such rules is not questioned. They attacked the decision as out of harmony with later English and American cases[69] and cited *Harris v. Thomas,* where, on

[60] Def. Brief, 15-16.
[61] 1 Sumn. 516, 18 Fed. Cas. No. 10388 at 507 (C. C. D. Me. 1834).
[62] 286 U. S. 427, 436 (1932).
[63] 283 U. S. 643, 653 (1931).
[64] 272 U. S. 425, 429 (1926).
[65] Gov. Brief, 176-178.
[66] *Id.* 179.
[67] *Id.* 178.
[68] Def. Brief, App. "A," p. 61.
[69] *Id.* 41-42.

facts similar to the *Pratt* case, the court said: "If appellees were acting to further their legitimate purpose, or to advance the practice of their profession, this, we think, would be justified even if it had the result claimed by appellant. Unless the organization was itself illegal or the methods used by it were wrongful, appellant has no just complaint."[70]

The government contended the *Harris* case was not applicable because it had been decided on the pleadings, where the allegations of the answer, not the complaint, had been taken as true, whereas in the principal case, the defendants' demurrers admit that they had an unlawful purpose and that they used unlawful means to effectuate it.[71]

Judge Proctor, in ruling on the demurrer, accepted the defendants' contentions on this point. He ruled that the practice of medicine was not a "trade" within the meaning of Section 3 of the Sherman Act. He declared that the Supreme Court, in the *Atlantic Cleaners* case, undertook to give a definition of "trade," as required by the issues in the case, and that, in so doing, the Court found "trade" to be used in Section 3 in the general sense attributed to it by Justice Story.[72]

Concerning the restrictive covenant cases cited by the government to show that at common law the practice of medicine was considered in the category of "trade," the court said: "At most such cases serve only to illustrate the development of a legal doctrine, having its origin in contracts concerning tradesmen, which became known as the doctrine 'against restraint of trade,' and which in course of time was extended and applied to agreements by doctors respecting their professional practice."[73]

The court distinguished the *Pratt* case, commenting on the similarity of the fact situations, but pointing out that the *Pratt* case involved a civil suit for damages, founded on common-law principles involving malicious injury to another's means of livelihood, while the present case involved a statutory criminal prosecution, the gist of which was combination and conspiracy.[74]

Argument that GHA and the Washington hospitals are engaged in trade were also based on the "money's worth" concept of "trade" and were disposed of by the court in the same way. In so doing, the court defined "trade" in the broader sense as the class "of *manual* or *mercantile* pursuits, carried on for *profit or gain* without buying or selling of goods."[75] The dry cleaning business, held to be a trade in the *Atlantic Cleaners* case, comes within this definition, since the "very essence of that service was the skillful use of labor and materials."[76]

The court refused to accept the "money's worth" definition of trade, on the ground that it would include all gainful occupations and so do violence to the common understanding of "trade." If Congress had had such an intent, it would

[70] 217 S. W. 1068, 1076 (Tex. 1920).
[71] Gov. Brief, 89.
[72] 28 F. Supp. at 755.
[73] *Ibid.*
[74] *Id.* at 756.
[75] *Ibid.*
[76] *Ibid.*

have made its purpose clear. "Certainly it is not for the courts to stretch an old statute to fit new uses for which it was never intended."[77]

*Additional Questions Before the Court*

A further claim by the defendants that GHA, being unlawfully engaged in the practice of medicine and insurance, could not be the subject of restraint within the Sherman Act[78] was met by the government with three arguments: (1) since the allegations of the indictment are the only facts before the court on the demurrer, the legality of GHA's acts cannot be questioned in argument on the demurrer; (2) the decision in *Group Hospital Association, Inc. v. Moor*[79] that GHA is not engaged in the practice of medicine or insurance offers strong authority for such a conclusion in this case; (3) even were GHA so engaged, defendants could not justify their conduct on the illegality of GHA, since it is for the government to question such illegality.[80] The court agreed with the government's contention that the allegations of the indictment did not show that GHA was engaged in medical practice or insurance.[81]

The defendants also questioned the constitutionality of Section 3 of the Sherman Act. They argued that since the meaning of "trade and commerce" in Section 3 is not limited to interstate commerce, as in Section 1, the meaning of "trade" is so vague and indefinite as to make the criminal provisions fatally defective for want of an ascertainable standard of guilt and, therefore, repugnant to the due process clause of the Fifth Amendment and to the Sixth as well.[82] The government replied that the Supreme Court had held that Section 1 of the Sherman Act is not void for want of certainty[83] and that the word "trade" certainly has a more definite meaning than "interstate commerce." The court did not agree with the argument of the defendants, but held that it was unnecessary to decide the issue of constitutionality, since the case could be decided on other grounds.[84]

[77] *Ibid.*
[78] Def. Brief, 54.
[79] 24 F. Supp. 445 (D. C. 1938).
[80] Gov. Brief, 191.
[81] 28 F. Supp. at 758.
[82] Def. Brief, 47-48.
[83] Gov. Brief, 47-48, citing Nash v. U. S. 229 U. S. 373 (1913).
[84] 28 F. Supp. at 758.

# THE BACKGROUND OF THE WAGNER NATIONAL HEALTH BILL

HAROLD MASLOW*

The introduction of Senator Wagner's National Health Bill[1]—S. 1620, to use its legislative tag—topped off a series of earlier efforts in the direction of health reforms. The bill itself—the administrative machinery provided and its content—is by no means novel but is based on earlier experience. Behind all the studies, the conferences, the legislative battles, the earlier enactments and efforts, lie a group of socio-economic forces which may be considered the "real causes" for these various happenings. The treatment of these earlier endeavors at health reform will, for the sake of clarity, be divided into a chronological account of the general efforts, and a description of the previous administrative experience in the special fields covered by the Wagner Bill. The broad societal forces in the background will be sketched separately.

## THE GENERAL EFFORTS IN THE BACKGROUND

A history of the modern attempts at health reform is usually begun with the lively health insurance movement about the time of the World War. This movement was primarily set off by the passage in 1911 of the British health insurance law.[2] Compulsory health insurance bills were introduced in a dozen legislatures, and some of them appointed legislative commissions to investigate the proposal. Several commissions gave a favorable report, but no bill was passed, although New York came within a few votes of enactment. By 1921 interest had died down. According to Rubinow, who played an active part in this early movement, the main cause for the failure to enact any law was the inclusion of a small funeral benefit in these bills. This clause brought on the powerful opposition of the industrial insurance companies whose business is recognized as being essentially burial insurance. The American Medical Association did not either officially oppose or approve the legislation; some

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[1] S. 1620, 76th Cong., 1st Sess., introduced Feb. 28, 1939, is comprised of five sections. Section 1 states the purpose and popular title of the Act; §2 amends Title V, parts 1, 2, and 5 of the Social Security Act; §3 amends Title VI; §4 adds new titles XII, XIII, and XIV to the Act; §5(a) amends §1101(a)(1), (2); §5(b) adds a new subsection (e) to §1101. In this article citation hereafter will be made to the title, part, and section numbers of the Social Security Act, as amended by the bill, rather than to the section numbers of the bill.

[2] National Insurance Act, 1911, 1 & 2 GEO. V, c. 55.

of the component state and county medical societies vigorously opposed, but some approved the proposal. While the American Federation of Labor conventions also took no stand, the weight of President Samuel Gompers and the Executive Council was definitely placed against the measure. Some state federations of labor followed Gompers's strong anti-state philosophy and disapproved. Others, such as the New York federation, energetically pressed for the legislation. The American Hospital Association and the National Organization for Public Health Nursing endorsed compulsory health insurance at this time.[3]

Interest was also shown in federal grants for public health work in the states during this period. The Chamberlain-Kahn Act,[4] passed in 1918, set up a system of federal grants for state venereal disease programs. Senator France, a Republican and a physician, introduced in 1919 a bill which provided for federal public health grants-in-aid of $15,000,000, and federal grants for hospital construction of $48,000,000.[5] That same year, Representative Mann introduced a bill providing federal grants of $1,000,000 a year for rural public health work.[6]

The public psychology in the halcyon 'twenties was not favorable for a consideration of social problems and little was heard of health reforms. The American Medical Association in 1921 formally denounced compulsory health insurance. Congress permitted the federal program of venereal disease grants to lapse, but in 1921, after several years of strong public agitation, it enacted the Sheppard-Towner[7] Bill for federal grants to state infant and maternal hygiene plans. The decade was marked by a development of interest on the part of the private foundations: the Commonwealth Fund and the Milbank Memorial Fund demonstrations showed, by actual practice, the life-saving possibilities of our modern public health science. It is of some interest to quote from a 1921 editorial by Dr. Glenn Frank, now chairman of an official committee on whose report the Republican Party will presumably base its 1940 platform:

> "A quit-claim deed to immortality is awaiting the surgeon, physician, or statesman who can think of health in terms of a nation instead of a patient, and who can effect the beginnings of a national health program that will insure to every man, woman and child in the United States the full and continuous benefits of the best in medical science and service."[8]

Dr. Frank then went on to advocate a system of complete state medicine which is today considered as too radical and impractical politically by students of the subject.

Several foundations provided the initiative and a $1,000,000 grant for the Committee on the Costs of Medical Care which launched a five-year, comprehensive, fact-finding program after its formation in 1927. The chairman of the CCMC was Dr. Ray Lyman Wilbur, a former AMA president and a Hoover cabinet member. The 28 volumes produced by the CCMC up to 1932 gave a tremendous fillip to dis-

[3] See RUBINOW, QUEST FOR SECURITY (1934) 207-217; MILLIS, SICKNESS AND INSURANCE (1937) 118-121.
[4] 40 STAT. 886 (1918).
[5] S. 2507, 66th Cong., 1st Sess. (1919).
[6] H. R. 10510, 66th Cong., 1st Sess. (1919).
[7] 42 STAT. 224 (1921).
[8] *Trailing the Robin Hoods of Medicine* (1921) 102 (N. S. 80) CENTURY MAGAZINE 955.

cussion of the health problem, especially in professional circles. The majority report of the Committee made the following recommendations: (1) the expansion of group practice through hospitals or group clinics, (2) a marked extension of public health work, (3) the development of group payment for medical care through insurance or taxation, and (4) the formation of agencies to co-ordinate the community health resources. It was also suggested that federal grants be made for medical care in the poorer states.[9] Aside from its broad intellectual stimulation, the CCMC was an important factor in influencing the American Hospital Association to endorse group hospitalization in 1933 and in inducing a greater medical society interest in the organization of plans for medical care.

President Roosevelt in 1934 appointed the Committee on Economic Security to draft a Social Security Bill. The general understanding was that the Committee would include a health insurance title, but when the bill was presented to Congress no such measure was provided.[10] The active opposition of the American Medical Association is usually recognized as the cause for this omission. However, an ambitious program of federal grants for public health work, infant and maternity hygiene, and crippled children care was provided by the Act. At the extensive social security hearings, practically no opposition was voiced to these titles of the bill. The American Medical Association did not appear at the hearings. The 1939 Congress readily provided increased appropriations for these federal grants under the Social Security Act, when the states evinced a desire for further expansion.[11]

As regards medical care, the main development since the CCMC has been in the field of voluntary health insurance, especially group hospitalization. The federal government, through the Farm Security Administration, has worked out a hybrid voluntary-governmental, insurance-relief, medical care program for the FSA clients. In the states, compulsory health insurance bills are once again being introduced in noticeable numbers. The California State Medical Society in 1935, when the local political temper made a compulsory law a definite possibility, formally endorsed such legislation, although this position has since been changed. Wisconsin is another state where health insurance is being actively discussed. The recent passage of a law in British Columbia has had some influence in the states, and bills which slavishly follow that enactment have been introduced in Massachusetts and Washington. The American Association for Social Security Model Bill has also been introduced in several states. In New York State, the 1938 constitutional convention approved an amendment that would make constitutional the enactment of a compulsory health insurance law, and when this amendment[12] was submitted to the voters, it received

[9] COMMITTEE ON THE COSTS OF MEDICAL CARE, MEDICAL CARE FOR THE AMERICAN PEOPLE (1932) 122.

[10] For a discussion of the health insurance problem, see COMMITTEE ON ECONOMIC SECURITY, REPORT TO THE PRESIDENT (1935) 41-43.

[11] Pub. No. 379, 76th Cong., 1st Sess. (1939) tit. V. See Sen. Comm. on Finance, "Social Security Act Amendments of 1939," Sen. Rep. No. 734, 76th Cong., 1st Sess. (1939). Also, Sen. Comm. on Finance, "Hearings on Social Security Act Amendments," H. R. No. 6635, 76th Cong., 1st Sess. (1939) p. 423. See Miss Lenroot's comments at bottom of p. 431.

[12] N. Y. CONST. art. VII, §8.

the largest vote of any of the proposed amendments. This state has a legislative commission now studying health insurance.

In 1936 the American Foundation conducted a survey of opinion amongst a cross-section of the medical profession, and much interest has been shown in the resulting two volumes published by the Foundation.[13] They reveal an amount of individual professional approval for the various forms of socialized medicine which is surprising in view of the opposition by the most important organization of doctors, the American Medical Association. As a direct outcome of this study, the important Committee of Physicians for the Improvement of Medical Care was formed, composed of a small group of prominent physicians, whose purpose seems to be to influence the AMA away from its conservatism. This Committee appeared at the hearings on the Wagner National Health Bill in favor of the measure.[14]

Immediately after the passage of the Social Security Act, the President appointed an Interdepartmental Committee to Co-ordinate Health and Welfare Activities. This Interdepartmental Committee, under the chairmanship of Miss Josephine Roche, then Assistant Secretary of the Treasury, duly appointed a subcommittee, the Technical Committee on Medical Care, to continue the studies in medical care of the 1934 Committee on Economic Security. The Technical Committee, in February 1938, submitted two reports, "The Need for a National Health Program," and "A National Health Program,"[15] in which it sketched a picture of lag in bringing to the people the many new developments in the medical sciences and proposed a ten-year plan for a progressively increasing program of federal grants to encourage health work in the states. The President suggested that the National Health Program be placed before a public conference and, accordingly, in the hot summer of 1938, about 200 leaders in American life representing the professions, labor, farmers, and various civic organizations, came to the memorable National Health Conference. It is generally agreed that the dominant note was a definite approval of the National Health Program, although the American Medical Association disapproved the plan.[16] Probably the main significance of the National Health Conference lies in the fact that it actively brought into the discussion of health reforms, thus far largely monopolized by the professional groups, such lay organizations as the American Federation of Labor and the American Farm Bureau Federation, which play a large role in the shaping of legislative policy. Since the National Health Conference, the tendency has been generally to accept the existence of unmet health needs and to focus public discussion upon the problem of selecting techniques for meeting these needs.

The President sent the reports of the Technical Committee to the 1939 Congress

[13] AMERICAN FOUNDATION, AMERICAN MEDICINE: EXPERT TESTIMONY OUT OF COURT (1937).

[14] Hearings before a Subcommittee of the Senate Committee on Education and Labor on S. 1620, ("to Establish a National Health Program") 76th Cong., 1st Sess. (1939). (Hereinafter cited as "Hearings on S. 1620.")

[15] The reports were transmitted with a message from the President of the United States to the Congress, January 23, 1939. H. R. Doc. No. 120, 76th Cong., 1st Sess., reprinted in Hearings on S. 1620, at 17.

[16] INTERDEPARTMENTAL COMMITTEE TO CO-ORDINATE HEALTH AND WELFARE ACTIVITIES, PROCEEDINGS, NATIONAL HEALTH CONFERENCE, July 18, 19, 20, 1938.

with a message recommending their "careful study," and, subsequently, Senator Wagner introduced S. 1620 which substantially incorporated the National Health Program. A subcommittee of the Senate Committee on Education and Labor conducted unusually extensive hearings[17] on the bill at which various labor and farmer groups appeared in favor of the measure, while the American Medical Association appeared in opposition. In August 1939, Senator Murray of Montana submitted a preliminary report for the subcommittee which stated that the subcommittee "is in agreement with the general purposes and objectives of this bill," but that "additional study" is desirable, and that "the subcommittee intends to report out an amended bill at the next session of Congress."[18]

### THE SPECIAL EXPERIENCE IN THE BACKGROUND

Significantly, the Wagner Bill takes the form of amendments to the Social Security Act, and a good deal of the bill provides for merely an expansion of the existing health titles of the Act.[19] In the fields untouched by the Act, but covered by the bill, there is also a substantial body of precedent. This background of experience will be examined in connection with each type of aid proposed by the bill.

*Grants for Maternal and Child Welfare.* The federal government passed in 1921 the Sheppard-Towner Act[20] which provided grants to the states for maternal and child health, a system that was continued until 1929. At the 1921 hearings[21] on that bill, the proponents pointed to a high infant and maternal death rate, especially in rural areas, as compared with other countries. Various demonstrations had shown that the death rates could be reduced, but the necessary techniques were not being extensively applied. It was urged that federal grants would greatly encourage their adoption in the states. The Catholic Social Welfare Council, the AFL, the National Consumers' League, and other organizations appeared in favor of the bill. President Harding recommended its passage in his message to Congress. The opposition to the measure came from several state medical societies and anti-women's suffrage clubs. The opponents argued the need for tax economy, the inadvisability of federal control of local health work, and the possibility of lay control. Some friends of the bill opposed its administration by the Children's Bureau of the Labor Department instead of by the Public Health Service, and, accordingly, the Act, as passed, provided for a Federal Board of Maternity and Infant Hygiene, composed of the Surgeon General of the Public Health Service, the Federal Commissioner of Education, and the Chief of the Children's Bureau, that was to lay down the regulations by which the Children's Bureau dispensed the grants. The Act gave an annual appropriation to the Children's Bureau of $1,240,000 for this work.

[17] See note 14, *supra.*

[18] See Hearings on S. 1620; Senate Committee on Education and Labor, "Establishing a National Health Program," SEN. REP. No. 1139, 76th Cong., 1st Sess. (1939) 1.

[19] See note 1, *supra.* [20] *Supra* note 7.

[21] Hearings before House Committee on Interstate and Foreign Commerce on H. R. 2366, 67th Cong., 1st Sess. (1921); Hearings before Senate Committee on Education and Labor on S. 1039, 67th Cong., 1st Sess. (1921).

During the Sheppard-Towner period, almost 3,000 new permanent centers for child health or maternity hygiene, or both, were established. This represented a great development of the child health center idea, which has been traced back to the Strauss Infant Milk Stations, first organized in New York City in 1893. In 1910, only 42 organizations located in thirty cities were maintaining baby health stations. The Act appears to have definitely stimulated maternal and infant work, which, however, abated somewhat after the federal grants ceased. In 1928, $2,158,000 was spent for these activities of which the states supplied about 55%, while in 1934 the states were spending only a million dollars in this field.

Strong efforts were made to renew the legislation after Congress allowed it to lapse in 1929, but they were not successful in the face of the reigning political conservatism. The American Medical Association opposed continuation of the system in the sweeping terms of a resolution of its House of Delegates: "Resolved that the House of Delegates condemns as unsound in policy, wasteful and extravagant, unproductive of results and tending to promote communism, the federal subsidy system established by the Sheppard-Towner Maternity and Infancy Act and protests against a renewal of that system in any form."[22] Appearing against the bill at the hearings in the 71st Congress, were the Sentinels of the Republic, the Woman Patriots of Massachusetts, and the AMA.

Title V of the 1935 Social Security Act revived the Sheppard-Towner system but on a much greater scale, providing $3,800,000 for the work. In its administration, the Children's Bureau has been emphasizing the basic machinery for state programs, such as the establishment of a maternal and child health division in each state health department, extension of public health nursing, and the development of training courses for doctors and nurses. According to Miss Katherine Lenroot of the Children's Bureau: "As developed up to the present time with the limited financial resources available, the program is chiefly one of health education and health supervision."[23] Relatively little has been done in regard to medical care at childbirth, nutrition work and social work. The states submitted plans for 1939, approved by the Children's Bureau, totalling $4,229,000, well in excess of the federal appropriation.

Congress in 1939 increased the appropriation for this work to $5,820,000.[24] The Wagner Bill would provide the sum of $8,000,000 for the first year after its enactment, $20,000,000 for the second year, and $35,000,000 for the third year.[25]

*Federal Grants for Crippled Children Programs.* Immediately preceding the passage of the Social Security Act, 35 states were spending about five and a half million dollars per year for locating, diagnosing, and treating crippled children, most of whom were paralytics. No federal aid had ever been given for this work until the Social Security Act appropriated $2,850,000 for federal grants-in-aid.[26] Today all the

[22] Hearings before the House Committee on Interstate and Foreign Commerce on S. 255 and H. R. 12955, 71st Cong., 3d Sess. (1929) 173.

[23] *Health Security for Mothers and Children* (March, 1939) 202 ANNALS 107.

[24] Pub. No. 379, 76th Cong., 1st Sess. (1939) §501.

[25] Nat. Health Bill, tit. V, pt. 1, §501. (Appropriations are merely authorized by the Bill.)

[26] Although Senator Copeland introduced in 1930 two bills concerning federal grants to state crippled

states have crippled children programs, and they are more liberal than formerly in regard to age and income eligibility requirements. In the first years of this federal program, the full annual appropriation was not used up, but the budget requests from the states for 1939 exceeded it. The 1939 Congress increased the appropriation to $3,870,000.[27] The Wagner Bill would provide the sum of four million dollars for the first year, and five million dollars for the second year.[28] The Wagner Bill would provide a still larger sum for "medical care of children,"[29] in addition to the crippled children work.

*Federal Grants for Public Health.* The federal government, through the United States Public Health Service, has for many years stimulated state and local public health work, and national leadership is today generally expected from the Service. Its leadership has been exerted through the annual Conference of State and Territorial Health Officers since 1902, the publication of bulletins and reports, the creation of standards for public health work, special field surveys, demonstration projects, and finally grants-in-aid.

The Public Health Service conducted a program of demonstration projects in the states after 1917 for which Congress appropriated about $300,000 in its later years. Where a state or locality agreed to share the costs of a demonstration, the Public Health Service would set up a project in the hope that the locality would take over the whole expense at the end of the demonstration period. It is an easy transition from such a program to regular, continuous grants-in-aid.

The Public Health Service conducted a federal grants-in-aid program for state venereal disease work under the Chamberlain-Kahn Act of 1918.[30] This law marks the first application of the grants-in-aid device to the field of health. Congress appropriated $1,000,000 a year for grants to the states, but steadily reduced this sum after 1920. By 1925, no appropriation at all was being made to continue the program, although practically no opposition had been voiced against the passage of this law, and no friction had developed between the state and federal health authorities in its administration.[31] The conservative political temper and the puritanical social attitudes still prevailing in the twenties appear to have led to the cessation of the system. In 1938, after an intensive syphilis education movement with which the Surgeon General, Dr. Thomas Parran, was closely associated, Congress again set up the system,[32] but on a broader scale, providing $3,000,000 a year for the work. At the hearings on the bill, nobody appeared in opposition, while several doctors and a state medical society appeared in favor of it.[33]

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children programs, one of which provided three million, and the other six million dollars. S. 3336 and S. 3639, 71st Cong., 2nd Sess. (1930).

[27] *Supra* note 24, §504.

[28] Nat. Health Bill, tit. V, pt. 2, §512.

[29] *Ibid.* $9,000,000 is authorized for the first year, $11,000,000 for the year following. For subsequent years a total appropriation of $35,000,000 is authorized, to be divided between the two purposes in such proportions as the Children's Bureau deems necessary.

[30] *Supra* note 4.

[31] LEIGH, FEDERAL HEALTH ADMINISTRATION (1927) 405-412.

[32] 52 STAT. 439 (1938).

[33] Hearings before the Senate Committee on Interstate Commerce on S. 3920, 75th Cong., 3d Sess. (1938).

The 1935 Congress which enacted the Social Security Act was presented with some evidence of a breakdown in public health work in the states due to the depression. The Federal Emergency Relief Administration took the unusual step of giving $1,000,000 to the Public Health Service for aids to rural public health work.[34] Title VI of the Social Security Act provided $8,000,000 a year in grants to the states for public health work, and much progress has followed these grants. On January 1, 1935, 594 out of our 3000 counties were being served by a full-time health officer, while at the close of 1938 this useful index of public health work had jumped by more than 100% to 1371 counties. This federal money has gone mainly towards the erection of the basic state and local health department machinery; little has been done in the way of developing such special services as industrial hygiene. Ample testimony was given at the hearings on the Wagner Bill that this co-operative program is being conducted with no friction between the states and the Public Health Service.[35]

The 1939 Social Security Act amendments included an increase of the federal appropriation for general public health grants to $11,000,000.[36] The Wagner Bill would provide amounts for public health grants which are several times larger than this appropriation.[37]

*Grants for Hospital and Health Center Construction.* The modern hospital has become essential to a high quality of medical care in a community. The hospital of today is a workshop for the doctor, a medical research center, a post-graduate school for the practitioner, a training place for young internes and nurses, and sometimes a center for public health work. The rural health center may be considered as a substitute hospital, not having all the facilities of the latter, but suitable for sparsely settled areas which cannot afford a hospital.

State and local governments have, for many years, assumed the burden of hospitalizing the sick poor, especially for the expensive chronic ailments. It is widely recognized that they have lagged lamentably in the proper provisions for the tuberculous and the mentally ill. Churches, fraternal orders and community associations have built many general hospitals operated on a non-profit basis, which specialize in caring for those able to pay although they have a long tradition of also caring for charity cases. Since about 70% of the funds of the voluntary hospitals comes from patients' fees, these institutions are hard hit by a depression. The widespread practice of giving tax funds to voluntary hospitals for the indigent cases, may eventually be developed as an important depression bulwark for this group of hospitals, and in this connection, the provision of the Wagner Bill concerning federal grants for medical care[38] has definite potentialities.

The federal government, through the Public Works Administration and the

[34] SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE, ANN. REP. 1935, p. 67.

[35] See, *e.g.*, the testimony of Abel Wolman and Dr. Felix Underwood, Hearings on S. 1620, pp. 130-139, 540-542.

[36] *Supra* note 24, §509.

[37] Nat. Health Bill, tit. VI, pt. 1, §601. The amount authorized for the first year is $15,000,000; for the second year, $25,000,000, for the third year, $60,000,000.

[38] Nat. Health Bill, tit. XIII.

Works Progress Administration, entered the field of hospital construction as a part of its broad re-employment program. Since 1933, PWA has helped construct new hospitals, extend old ones, and install modern equipment in inadequate institutions. These projects have provided 51,000 additional hospital beds, an appreciable dent in the problem caused by the falling off of hospital construction in the depression. PWA makes grants and also lends money to governmental bodies for construction purposes. From 1933 to 1936, PWA allotted $75,000,000 for hospital construction, about two thirds of which was in the form of grants, and the other third in loans.[39]

WPA has also done some work in the hospital field, mostly the repair and renovation of existing institutions. From 1935 to 1938, WPA constructed 101 new hospitals, built additions to 38, and improved 1,422.[40] WPA provides the labor, while the sponsoring governmental body supplies the materials and the land. WPA has also had some health center projects, notably those in New York City. The need for a hospital project is taken for granted by WPA, for it is assumed that the substantial local contribution required will assure only worthy projects. It is important to note that both WPA and PWA are not federal construction programs, for all projects, aside from the necessity for the sponsor's contribution, are initially requested by a local or state government body.

The Wagner Bill provides federal grants for general hospital construction totaling over $150,000,000 for the first three years,[41] or about twice as much as PWA allotted for all hospital work in a comparable period. In addition, a "sufficient" amount is to be appropriated for the building of more mental and tuberculosis hospitals. The Wagner Bill specifically authorizes the Public Health Service to utilize the experienced Federal Emergency Administration of Public Works in developing this program.[42]

*Grants to States for Medical Care.* This title of the Wagner Bill[43] would provide federal grants to state health insurance systems in the ordinary meaning of the term, to state systems of public medical care for the whole population, or to state plans for medical care of the needy, according to the wishes of the individual state.

Public medical care has been provided by the state or local governments to indigent persons since colonial days. Non-governmental agencies, especially the medical profession, have also dispensed free care to the needy, but the treatment of the indigent has become more and more a governmental function. Over the years, the state and local units of government have developed varying patterns of administration of public medical care, with a wide range in standards. In the bottom of the depression, these programs were threatened with disaster because of the great increase in the relief population and the corresponding fall in tax receipts. Accordingly, in 1933 the federal government for the first time, entered the picture of medical care

[39] Fed. Emergency Adm'n of Public Works, *PWA Provides Modern Hospitals* (1937).

[40] Works Progress Administration, Release No. 14329, *Physical Accomplishments on WPA Projects through June 30, 1938.*

[41] Nat. Health Bill, tit. XII, §1201. Part of the sum authorized is to be used to "assist the states for a period of three years in defraying the operating costs of added facilities."

[42] *Id.* §1203(c).

[43] Nat. Health Bill, tit. XIII.

for the needy through the famous Regulation No. 7 of the Federal Emergency Relief Administration. This administrative regulation stated that sickness care was a legitimate form of relief and that the regular federal program of grants-in-aid to the states for relief would also cover state programs for medical care in the home. The federal grants were to be confined to the severe emergency sicknesses, and were not to be used for hospitalization. By September, 1934, twenty states had programs in accordance with Regulation No. 7, thirteen states had partial programs, eight had none, and eight had continued their former systems.[44] When the federal government in 1935 assumed the care of the able-bodied unemployed through WPA, and left the remainder of the unemployed for the states and localities, this federal program for indigent medical care ceased. General relief standards have fallen since 1935, and it is to be expected that the medical care programs have especially suffered, since the hard-pressed relief authorities consider medical care as secondary to food and shelter in the relief budget.

Social need has caused the development of a trend towards broadening the coverage of public medical service beyond the totally indigent to the medically indigent, the group of self-supporting families who cannot afford to pay for a large sickness bill.[45] Thus, the American Medical Association now defines two groups as eligible for public medical care: the relief population who would need complete service, and the families earning up to $3,000 who would need varying degrees of public sickness aid.[46] The full significance of such a trend may be gleaned from the findings by the National Resources Committee that fully 92% of all the families earn less than $3,000. Parallel to this extension in medical relief, has been the realization that insurance facilities would permit most families of modest income to avoid public care. We may expect an increasing awareness by interest groups that health insurance will ease the present pressure on the property tax which now largely finances medical relief.

The wide development of voluntary health insurance, described elsewhere in this symposium, has tended to make of compulsory health insurance a concept which the public no longer regards as merely a foreign importation. The state workmen's compensation laws, with their increasing emphasis upon medical care, have also been considered a precedent for compulsory health insurance, especially by organized labor. President William Green of the American Federation of Labor has even suggested that health insurance be brought about by simply widening the scope of the present state workmen's compensation systems. On the whole, compulsory health insurance is much less radical an innovation than its opponents portray it to be.

*Grants For Temporary Disability Compensation.* This title[47] provides for federal grants to state disability compensation systems. Almost all the states have had some years of experience at administering a limited type of disability compensation, namely,

[44] AMA BUREAU OF MED. ECON., CARE OF THE INDIGENT SICK (1936).
[45] DAVIS, PUBLIC MEDICAL SERVICES (1937) 13.
[46] AMA BUREAU OF MED. ECON., FACTUAL DATA ON MEDICAL ECONOMICS (1939) 66.
[47] Nat. Health Bill, tit. XIV.

disability from work accidents or occupational diseases, under the workmen's compensation laws. Since the commencement of unemployment insurance payments, a demand has arisen for disability compensation on the part of the workers, for they see no common sense in the distinction between economic unemployment and sickness unemployment. The American theorists also attach importance to the present federal-state unemployment insurance program in so far as a disability law is concerned. The majority of our students hold that disability compensation should be administered by the unemployment insurance systems, so as to extricate the doctors from their difficult position, betwixt the patient urging liberal certification and the administration pressing for strict certification, commonly found abroad where disability payments have developed as an integral part of the health insurance laws. In that sense, the present federal-state unemployment compensation system may be considered a direct forerunner of the disability title in the Wagner Bill.

### THE SOCIETAL FORCES IN THE BACKGROUND

Behind the events and the legislative history sketched above lies a group of broad societal forces which have created the problem calling forth these laws and proposals, and which have also affected the suggested techniques for solution. The main factor in this causal complex is, undoubtedly, the cultural lag in our health practice which the Technical Committee on Medical Care has conveniently measured in terms of unnecessary deaths and preventable disease. Cultural lag is the maladjustment caused by the universal tendency for scientific discoveries to proceed at a faster pace than the necessary changes in our political and social institutions. These maladjustments may be described as follows:

a. The scientific advances in medicine have increased the cost of health care beyond the personal means of many families, and the community means of many local governments.

b. The new emphasis on prevention and early treatment of disease has been hampered by the traditional[48] fee-for-service system which discourages the consumer from such early care.

c. The progressively increasing accumulation of medical knowledge has made it difficult for the practitioner to keep up with these advances.

d. The modern requirements for expensive capital equipment, such as x-rays, has made the old private practice inadequate, creating a need for the medical workshops—hospitals, rural health centers, and group clinics.

e. The use of the division of labor principle in the health field (differentiating dentistry, public health work, surgery, etc.) necessitated by the vastness of medical knowledge, has created problems of co-ordination and many jurisdictional disputes.[49]

[48] But SHAFER, THE AMERICAN MEDICAL PROFESSION, 1783 TO 1850 (1936), gives evidence of the early existence of "family contracts."

[49] One important jurisdictional dispute may be described. In earlier days, public health work consisted of impersonal environmental measures, such as sewage disposal and water control, but modern public health practice has become personal (maternal and child hygiene) and even curative (syphilis control). Although the medical societies were the prime forces in the enactment of early public health legislation, the

In addition to causing this social lag, these technical advances, due to the new, profound, public respect for medicine's possibilities, have brought into the health picture an important social force for reform—a widespread public demand for health services. It is hard to realize that only a century ago, highly intelligent persons were of the opinion that doctors had nothing to offer to the sick. In the words of Shryock, the medical historian: "There was little concern in earlier periods (i.e., before 1880) as to whether or not all members of a community receive the attendance of a regular physician. . . . Few people complained in 1850 that they had no access to a hospital. They were only too happy to stay away from them."[50] This popular demand for modern medicine, plus the spectacle of only the richer families or the wealthier geographical areas being able to receive its benefits, plus our profoundly democratic tradition for equal opportunities to good living, obviously adds up to a powerful force for health reforms. Significant is the approach to the Wagner Bill by George St. J. Perrot, the secretary of the Interdepartmental Committee: "In essence the National Health Program aims to destroy the correlation between the receipt of health service and income."[51]

Another element, a political one, also has had an important bearing on the background of the Wagner Bill. This is the greater acceptance today of the governmental instrument as a means for social and economic reforms. The shock of the depression has jolted the traditional American *laissez-faire* philosophy, and now the average voter probably has much less objection to the further entrance of government into the health field. In this trend, the medical societies have not wholly participated for a host of reasons. The colorful language from a standard history of medicine may be quoted, for it differs only in degree of exuberance from sentiments commonly found in medical journals:[52]

"The objections of conservative practitioners to socialized or standardized medicine are that the people have already been cozened, stultified, nagged and enslaved by a complex network of superimposed laws and regulations, which are not true codified expressions of total public sentiment, but defeat their own object by encouraging evasion, chicanery, hypocrisy, vice, vulgarity, and corruption of the young; that to apply this principle to the practice of medicine is to degrade the physician to the level of a unionized vassal, destroy his individuality, encourage insolence of office and supercilious bureaucracy, with mere conventional handling or neglect of patients; in brief, to expose the science and art of medicine to the coxcombery of impertinent supervision by lay meddlers of Citizen Fixit type."

The federal government has come to play a principal role in these changing popular conceptions of the place of government. The dangers of overcentralization at Washington are real and have often been pointed out, but certain forces are operating to make at least federal financial grants necessary in many fields. The

new public health service has encroached on the practitioner's economic domain and has set up a definite and well-known tendency within the medical societies towards the restriction of public health activities.

[50] SHRYOCK, DEVELOPMENT OF MODERN MEDICINE (1936) 371.

[51] *Health as an Element in Social Security* (March, 1939) 202 ANNALS 136.

[52] GARRISON, HISTORY OF MEDICINE (4th ed., 1929) 797.

most important force is the inability of the states and local governments to find tax funds from which to finance new governmental benefits, because of their reliance on the property tax, adequate for the days of the "police state" but inadequate for the new "welfare state." After a discussion of the need for the county unit in rural public health work, Professor Lancaster goes on to say that "yet almost no rural county has organized such a unit of its own will."[53] The Lynds, scrutinizing social change in a typical American small city, made a similar comment to the effect that health innovations in "Middletown" generally came from the outside.[54] Realists like Beard recognize the evils of centralization but also realize the necessity of some federal intervention; the problem, to them, is to develop suitable techniques, such as federal grants-in-aid, government personnel training, advisory councils, merit systems, so as to avoid the dangers, and yet to retain the values, of federal participation.[55] Some consideration of the long history of our "state rights" controversy suggests that the opponent of S. 1620 who argues that the job belongs to the states and not to the federal government, really hopes that the job will not be done at all.[56]

*Summary*

It appears from our survey of the earlier events in the agitation for health reforms that the Wagner Bill is by no means a sudden development. Senator Wagner's bill would not be considered so seriously today if the public had not felt earlier agitations for reform. Nor can we consider the provisions of the Bill to be revolutionary. We have seen that the public health and hospital construction titles of the Bill are merely another step, albeit a long step, in the orderly development of existing federal health work, while the federal grants for medical care, and the disability compensation program, cannot be thought of as radical innovations, for they, too, have a broad body of precedent. After a consideration of the broad societal forces in the picture, attempts to explain away the Bill in terms of personal ambitions or of political expediency seem the product of superficial and perhaps wishful thinking. It is evident that the basic causation lies in the maladjustments created by the advances in the medical sciences, the deep desire of the public for the benefits of medical knowledge, and the average voter's acceptance of governmental activities in health work, especially on the part of the federal government.

[53] LANCASTER, GOVERNMENT IN RURAL AMERICA (1937) 339.
[54] LYND, MIDDLETOWN IN TRANSITION (1937) 399.
[55] BEARD, C. & W., AMERICAN LEVIATHAN (1930) 675.
[56] See, for a comment on this point, CLARK, THE RISE OF A NEW FEDERALISM (1938) p. X.

# PUBLIC MEDICAL SERVICES UNDER TITLE XIII OF THE NATIONAL HEALTH BILL*

DAVID F. CAVERS†

If major changes in the organization of American medical services were to follow from the enactment of the National Health Bill[1] in its present form, it would be principally by virtue of Title XIII which that bill proposes to add to the Social Security Act.[2] The proposed Title XIII authorizes grants-in-aid to states for the purpose of enabling them to "extend and improve medical care (including all services and supplies necessary for the prevention, diagnosis, and treatment of illness and disability)."[3] It is under this title that state measures establishing systems of compulsory health insurance might qualify for federal grants, and hence the title introduces what is assuredly the most controversial of the debated aspects of the national health program.

But, as the language quoted above makes obvious, Title XIII does not require the adoption of compulsory health insurance as a prerequisite to the grants it authorizes. On the contrary, it is couched in terms of unusual generality, terms which are sufficiently broad to permit the qualification of a diversity of other measures designed to "extend and improve medical care." Most, and perhaps all, such other measures can be comprehended in the broad category of "public medical services," namely, medical services administered by governmental agencies and supported by taxation.

Proposed state legislation establishing compulsory health insurance systems which might qualify for grants under Title XIII is discussed in the succeeding article in this symposium. This note will deal briefly with problems to be considered in devising state public medical service legislation to qualify for grants under that title. Although health insurance legislation would constitute a more drastic departure from past American practice and hence the issues of policy which it raises may be graver than

* In the organization of this symposium, provision was made for an article on this topic by a leading authority in the field. Circumstances which precluded his contributing to the symposium arose at a time too late to permit the enlisting of another contributor. Rather than omit all consideration of this important subject, this note was composed by the editor who makes no claim to first-hand knowledge of the field or expertness in its special problems.

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[1] S. 1620, 76th Cong., 1st Sess. (1939).

[2] The National Health Bill is comprised of five sections amending existing titles of the Social Security Act or adding new titles to it. Citations to provisions of the Bill will refer to the title and section numbers of the Social Securty Act, as amended by the Bill, and not to the section numbers of the Bill itself.

[3] §1301.

those posed by laws extending public medical services, nevertheless the questions presented by public medical service legislation may be of greater immediate importance. It would not be surprising if the states proved much more hesitant to resort to health insurance than to avail themselves of federal subsidies to augment services which, in greater or less degree, they are already providing. It is quite conceivable that there would develop systems of health insurance providing for certain employed groups of the population while public medical services were relied upon to assure care for the rest of those in need. Still another possible alternative is that the machinery of health insurance would be utilized to provide medical care to low-income and indigent persons for whom the state would make contributions.[4]

## I

Any consideration of the establishment of plans for public medical services under Title XIII requires discussion of the situation existing currently with respect to such services in the states as well as the specifications laid down by that title for the qualification of state plans for grants. Whatever plans may be developed under Title XIII, they will, of necessity, be influenced by the past and current experience of the states in the administration of tax-supported medical services.

This experience is not the product merely of the depression years. It is the outgrowth of state and local governmental activity in a number of related fields operating over a long period of time. Within the compass of this note, that experience can be sketched in only the briefest fashion.[5]

The English "poor law" of Elizabethan origin was the precedent for the assumption of legal responsibility for the medical care of the indigent by the American colonies and subsequently by the states. The responsibility fell upon the local unit of government, county, township, or municipality, and it was discharged as a rule in niggardly fashion. Often services were rendered by the physician who had succeeded in underbidding his competitors. Until hospitals gradually developed, it was the poorhouse which provided such institutional care as was afforded.

The development of the governmental hospital represented a step forward in the quality of public medical service, but the assumption of responsibility for hospitalization by government was not general. The non-governmental hospital, supported by charity, was relied upon to a considerable degree for general hospital service, whereas hospitals for tuberculosis, mental diseases, and contagious diseases were provided chiefly by government.

A third line of public medical service began with the development of public health services which were concerned at the outset primarily with preventive measures directed not toward the individual but toward the community in general. Responsibility for sanitation, for the prevention and control of communicable diseases, and for public health education fell under the jurisdiction of what might be termed

[4] Provisions to this end are found in the "model" bill of the American Ass'n for Social Security. See Reed, *Legislative Proposals for Compulsory Health Insurance, infra*, p. 632.

[5] The development and present forms of tax-supported medical care in the United States are surveyed in DAVIS, PUBLIC MEDICAL SERVICES (1937).

the "old-line" public health service. Gradually, however, the scope of the service's activities have been extending into the area of service to the individual. Thus, the maintenance of maternity clinics, the care of crippled children, the correction of certain ailments among school children likely to retard their educational progress, and, especially in recent years, venereal disease clinics have become a public responsibility.

Supplementing these varied public medical services in filling the needs of those not in a position to purchase medical care have, of course, been the private practitioners and the non-governmental hospitals. The former have performed a very considerable volume of gratuitous service; the latter, especially in their out-patient clinics, have also assumed a substantial share of the load.

The combined operation of these various agencies sufficed, prior to the depression, to prevent the plight of those forced to rely upon them from becoming so serious a problem as to compel more systematic provision for their needs. The load was not unduly heavy either on the local taxpayer or on the private physician and hospital. It was the onset of the depression which forced consideration of the weaknesses and inadequacies of the system. As relief loads mounted, tax receipts fell, and physicians' and hospitals' incomes diminished, while the demands for gratuitous services increased, a crisis was created in many communities and over widespread areas.

With the organization of the Federal Emergency Relief Administration came an effort to cope with this problem through the use of federal funds. Rules and Regulations No. 7 of FERA, declaring that "The conservation of the public health is a primary function of a government," laid the basis for an extensive program of medical aid administered in connection with federal unemployment relief.

This regulation established certain broad principles under which aid was to be administered. Responsibility for authorizing care was vested in the relief officials, free choice of physicians (among those willing to provide services under a reduced fee schedule) was to be maintained, no provision was to be made for hospital facilities which were to be provided as previously. The amount of service which could be rendered under a single authorization was closely restricted.

This regulation was issued in July, 1933. A study of its operation,[6] completed in June, 1934, indicated that 29 states were operating "successfully" along the lines it laid down. It seems clear that the degree of success attained varied considerably among those states and among communities within them, and also that success was in considerable measure relative to the conditions antedating the regulation.

With the extinction of FERA came the end of federal contribution to relief medical services, but the need for such services persisted. The plans set up under Regulation No. 7 have in some instances been maintained, but there seems to have been a general tendency to depart from the free-choice-of-physician principle in order to achieve the greater economies possible under salaried doctors or panels of limited size.

[6] LEUCK, MEDICAL CARE FOR THE UNEMPLOYED AND THEIR FAMILIES UNDER THE PLAN OF THE FEDERAL EMERGENCY RELIEF ADMINISTRATION (Am. Pub. Welfare Ass'n, 1934).

## II

Unfortunate for any effort to depict the situation as it now exists is the fact that comprehensive information is simply non-existent. Certain aspects of public medical services, hospitalization in state institutions, for example, are covered by relatively adequate statistics, but for most of the governmental activities only a vast amount of research would reveal the extent of service performed, its cost, its quality, and the legal powers and duties of those administering it.

A survey undertaken by the American Public Welfare Association summarized in the June 1938 report of its Committee on Medical Care[7] is perhaps as good a source as any of conditions prevailing in the nation. Some of the principal findings embodied in this report may be briefly summarized[8] as follows:

(1) As to the administration of public medical services, a veritable hodge-podge is revealed on both state and local levels. Roughly, responsibility is divided between departments of health and welfare, with special bodies in many cases charged with the administration of special institutional services. Not only does the division of responsibility follow no distinct pattern among the various states but the jurisdictional lines between the bodies within a single state are frequently blurred or overlapping. Still worse than the duplications are the gaps in authority which are often to be found. Efforts at coordination are rare and of such efforts many are relatively unsuccessful.

(2) Failure to utilize professional advice and supervision is common, even where authorized. Too often the services are dependent upon the views of a lay body, such as a board of county commissioners, charged with many other duties and often inspired chiefly by a desire to keep down expenditures.

(3) Intelligent planning and budgeting is impeded by the absence of adequate medical and financial statistics. Helpful comparison of such data as do exist is prevented by lack of standardization of statistical methods.

(4) On the vitally important problem of eligibility for medical care, no uniformity is to be found. Some jurisdictions provide only for those who are unable to support themselves when well. Other jurisdictions provide for care where recipients are found by financial investigation to be unable to acquire the services needed, although otherwise self-supporting. Still others provide for this group only in special "emergency" situations. "Pauper's oaths" and "means tests" are frequently employed. Some jurisdictions require patients to grant liens on their assets, including insurance, to secure future payment for services.

(5) Hospital service has provided problems where the government hospitals are non-existent or inadequate to carry the load. Payment is made to the non-governmental hospitals for service to indigent patients, but the basis for the payment, the

[7] The Committee's report was based on replies to questionnaires from welfare officials in 27 states and 54 cities and counties of over 100,000 population, including all parts of the country. In addition 36 localities in 17 states and Canada were covered by field trips. The survey was directed by Gertrude Sturges, M.D., consultant on medical care to the Association.

[8] In stating in very brief compass what I believe to be the gist of findings which extend over 35 pages, I may have been guilty of some over- or under-emphasis.

problem of controlling the length of stay, and the assurance of proper standards of care are sources of widespread difficulties. In some communities, unlicensed "nursing homes" are used to supplement hospital facilities, and public homes for the aged have been converted to institutions for the care of the sick.

(6) The physician's service is supplied either on the principle of free choice of physician operative through the device of a panel of physicians or by the employment of part- or full-time physicians on salary. Experience with neither system seems generally to have been satisfactory. Panel practice has proved more expensive and the work tends to gravitate to the hands of the least competent physicians. Low salaries, heavy case loads, and little opportunity for advancement result as a rule in an unsatisfactory class of salaried physician. In neither arrangement is adequate supervision generally provided, often none at all.

(7) Where dental services are provided, the tendency is to restrict the services sharply, usually to the relief of pain and the correction of conditions affecting employability. In this field the problem of panel versus salaried personnel is again encountered.

(8) Bedside nursing service is generally insufficient, often non-existent. Moreover, there seems to be a tendency not to utilize to the full such services as may be available. There is evidence of yielding to the temptation to conserve funds for physicians' services by failing to employ nursing services.

(9) Control of drug costs and methods of limiting the use of drugs are sources of difficulty. Prosthetic appliances—glasses, braces, and the like—are often given only when necessary to render the client employable.

This summarization of the report has excluded the brighter spots which occur in it. Yet the inclusion of the relatively few instances of successful administration which are reported would not materially relieve the darkness of the picture. Indeed, the exclusion of specific instances of maladministration in the summary probably more than compensates for the former omission. Yet certainly there exist in the nation many communities where the level of public medical service is on a plane distinctly above that described in the report. The report demonstrates an imperative need for reform, but it does not depict a hopeless condition.

## III

With this background, consider what measures must be taken if federal aid is to be obtained under Title XIII as proposed in the National Health Bill. The state plan must, as has been seen, have for its purpose the extension and improvement of medical care. However, this requirement is subject to a qualifying clause: "as far as practicable under the conditions in such State, especially in rural areas and among individuals suffering from severe economic distress."[9] Moreover, the major purpose of the plan is supplemented by the further purpose of enabling states "to develop more effective measures for carrying out the purposes of the title including the training of personnel."[10]

[9] §1301.

[10] *Ibid.*

At the outset uncertainty is encountered as to the content of the term "medical care." This is sufficiently broad to include virtually all types of public medical services which are directed toward the individual. Title XIII does not forbid the formulation of plans defining "medical care" thus broadly. Yet it is evident that the title was designed to assure improvement in the treatment of acute disease and chronic ailments other than those for which relatively satisfactory programs have already been or are being developed. Further, it seeks to discourage the development of "medical care" programs overlapping programs provided for in other titles of the Bill. The means to these ends is a provision in the section[11] prescribing the method of computing the federal matching grant. This provides that state expenditures "for the care, in hospitals, institutions and other organized facilities, of cases of mental disease, mental defectiveness, epilepsy and tuberculosis" shall not be counted, nor shall sums "included in any other State plan submitted for grants under this or any other Act of Congress." Hence to achieve a maximum grant under Title XIII the state medical care plan must not extend to these fields of public medical service.

Section 1303(a) prescribes the requirements which must be met by state plans to secure approval by the Social Security Board as eligible for federal grants. These will be listed with brief comment.

Clause (1) requires "financial participation by the State." The construction of comparable language in the Social Security Act makes clear that the state's participation may be through the medium of funds provided by its political subdivisions. The matching requirements will normally set the limits of state financial participation.

Clause (2) requires that the program be statewide or at least that the plan provide for the extension of the program so that coverage will be statewide by 1945. A question which might be raised by this provision is whether the plan must operate uniformly throughout the state. Social Security Board rulings on state old-age assistance plans indicate that this question may be answered in the negative. In view of the wide disparity in the needs of rural and urban areas, flexibility is highly desirable.

Clause (3) provides that the plan must be administered by the state health agency or by another state agency, but, in the latter event, the plan must provide "for cooperation and, when necessary, for working agreements between such agency and the state health agency." Provision is made to permit distribution of administrative functions among other agencies of the state and local governments if they are subject to the supervision of the state agency primarily charged with administration. It is evident that this provision permits each state to choose whether to vest administrative power in its health or welfare agencies. As has been pointed out, responsibility for public medical services is now quite generally divided between these agencies, and their jurisdictions are at times conflicting. The special demands of the depression have moreover produced many *ad hoc* emergency arrangements.

[11] §1304(a). No effort will be made to discuss in this note the problems presented by the computation of the federal matching grant. These are discussed in Heer, *A Study of the Formulae for Grants-in-Aid in the Wagner Bill, infra*, p. 666.

Opinion is divided within the membership of each of the two administrative groups as to the solution of the problem. There is marked tendency to regard the job as best suited to the other fellow. The explanation of this phenomenon may lie in the fact that the administration of medical care is extrinsic to the "old-line" work of each group. It represents a competitor for the funds available for those "old-line" duties and it calls for skills which "old-line" activities have not always developed.

No doubt the answer to this problem will vary from state to state. Administrative reorganization in some may be impeded by constitutional provisions prescribing departmental functions. In others political pressures may compel conformity to the contours of existing vested interests. In either case, it seems probable that the use of existing agencies could be made possible by the provision of supervisory controls linking the existing agencies to the central administrative body. However, attainment of optimum administrative organization would doubtless require rather thorough revamping of the existing system in most states.

Clause (4) requires provision of efficient methods of administration, especially a merit basis for personnel and "standards of medical and institutional care and of remuneration" therefor prescribed by the state agency after consultation with professional advisory committees. The civil service provision should operate to purge many state and local health administrations of political influences which have impaired their efficiency. Much progress was made toward achieving state merit systems under the Social Security Act even before its 1939 amendments granting direct power to the Board to condition grants on the adoption of merit systems.[12] Where political appointees are firmly entrenched in local agencies, their duties can often be restricted to work which is not aided by federal grants.

The requirement that professional guidance be obtained as to standards of care and remuneration should diminish professional opposition to lay dictation as to such matters, without, however, compelling a surrender of ultimate state responsibility therefor.

Clause (5) requires that the plan "provide for an advisory council or councils" representing the professions, public and private agencies furnishing services under the plan, and informed members of the public. The requirement is designed both to correct the tendency, now prevalent, to fail to utilize professional advice and to assure that the advisory function is not deemed the exclusive prerogative of the professions. The requirement in clause (4) assures that the functions of at least the professional councils will be far from nominal.

Clause (6) requires the state administrative agency to make such reports as the Board may require. Not only would the operation of this clause end the existing

[12] The Social Security Act, in the sections prescribing criteria for federal approval of state plans under the various titles, expressly excluded methods of administration "relating to selection, tenure of office and compensation" from consideration by the federal agencies. The 1939 amendments permit the approving agency to require "personnel standards on a merit basis" but not to exercise authority over "the selection, tenure of office, and compensation of any individual employed in accordance with" such standards. See, *e.g.*, Social Security Act Amendments of 1939, Pub. No. 379, 76th Cong., 1st Sess. §101(a)(5).

shortage of data concerning public medical services, but it would also permit the standardization of the data made available so that comparison would be feasible.

Clause (7) requires provision for "cooperation and, when necessary, for working agreements," between the state agency and public agencies administering related services such as "welfare assistance, vocational rehabilitation, social insurance, workmen's compensation, labor, industrial hygiene, education, health or medical care." It seems fair to assume that time would be allowed for the perfection of the system of coordination envisaged by this clause, but ultimately it should operate to break down the present tendency toward compartmentation in what is essentially an integrated field.

Clause (8) requires that the state agency be vested with authority to issue necessary rules and regulations, an obvious necessity.

As has been seen, the title leaves a considerable range of choice of the states as to the nature of the medical care to be provided by their plan. Other important choices are also left open. Chief among these are determinations as to eligibility to receive care, the types of medical care to be provided, and the basis for utilizing physicians' and hospital services.

As to eligibility, the emphasis in the statement of the purpose of the grants upon aid to "individuals suffering from severe economic distress" suggests, if it does not require, that this group should be provided for if others are to be served, a consideration of concern in the planning of health insurance systems but scarcely of public medical services. Apparently, the states are free to insist, as some now do, upon pauper's oaths and means tests to assure that the recipients are not self-supporting. Yet the goal of extending medical care seems to anticipate serving at least the "medically indigent," a term which is susceptible of very liberal definition.

There is evidence of a growing belief that public medical service should be placed in the same plane as public education and that the applicant for medical care should not be exposed to the humiliation of demonstrating his economic dependency. There would seem nothing in the requirements of Title XIII to preclude so comprehensive a program from being developed.

At the hearings before the Subcommittee of the Senate Committee on Education and Labor, representatives of various schools of practitioners and of allied professions appeared to request specific provision for the participation of their services in the state plans. In its "Preliminary Report" the Subcommittee restated what was doubtless the intention of the draftsmen, namely, that this problem should be left to the discretion of the states in whose jurisdiction the licensing and regulation of the healing arts has always fallen.[18] It seems probable that this solution of the problem would persist in any federal legislation which might be enacted.

The title does not influence the choice by the state of the method of remunerating physicians providing service under the plans. But new conditions may. Free choice of physician is an ideal which requires for its attainment a degree of professional co-

[18] See Prelim. Report, "Establishing a National Health Program," Subcomm. of Sen. Comm. on Education and Labor, S. REP. No. 1139, 76th Cong., 1st Sess. (1939) 35.

operation that may be difficult to secure and certainly to maintain throughout a state. On the other hand, the sounder financial basis for the new plans and their more efficient administration should result in a better salaried staff and in the supplementation of their services by the use of specialists and consultants and, when peak loads were encountered, general practitioners.

The development of satisfactory arrangements for hospital care under the plan contemplated by Title XIII seems relatively simple of achievement.[14] It is important in this connection to point out that this title contains an answer to criticisms raised by medical and hospital authorities concerning the failure of Title XII to provide aid to existing hospital facilities along with its provision for the construcion of new ones. A comprehensive and adequately financed system of public medical care would assure to existing non-governmental hospitals a considerable increase in the volume of patients at compensatory rates.

This observation of course presupposes sufficient appropriations. The title authorizes a federal appropriation of $35,000,000 for the first year and thereafter of a sum "sufficient to carry out the purposes of this title."[15] It is probable that the primary limiting factor will be the state rather than the federal appropriation. The limitation contained in the title that in computing the matching grant "so much of each total expenditures by the State and its political subdivisions as are. . . . In excess of $20 annually per individual eligible for medical care under such plan"[16] will, it may be suspected, represent for many years to come more a counsel of perfection than a restriction.

Even if those states which were first to take advantage of the federal grants contemplated by Title XIII should not increase their total expenditures for medical care, the gain to the public medical services would certainly represent far more than the increment of federal money. To the extent that the findings of the American Public Welfare Association's committee are representative of public medical services, it seems inevitable that the establishment of plans in conformity to Title XIII's specifications would assure a far more efficient use of those dollars that are appropriated than is now the case. And the efficient administration of an appropriation affords the best basis for obtaining greater sums where these are needed to meet human needs.

[14] A basis for the development of this aspect of state plans is already laid in a statement of principles developed by a joint committee of the American Hospital Association and the American Public Welfare Association on "Relations Between Public Authorities and Hospitals." The committee's statement is printed in *Hospital Care for the Needy* (1938) 12 HOSPITALS, No. 8, p. 17.

[15] Nat. Health Bill, §1301.

[16] *Ibid.* See note 11, *supra.*

# LEGISLATIVE PROPOSALS FOR COMPULSORY HEALTH INSURANCE

LOUIS S. REED*

The Wagner National Health Bill[1] provides in Title XIII for federal aid to state general medical care programs. The language of this title is sufficiently broad so that states setting up compulsory health insurance or comprehensive tax-supported public medical care systems (or more limited programs) would be entitled to financial assistance from the federal government in carrying on these programs provided certain specified requirements are met. This financial assistance would amount to between one sixth and one third of the total expenditures under the state program depending upon the relative financial resources of the state.

The purpose of this article is to examine legislative proposals which have been made for state compulsory health insurance and to discuss certain of the issues involved in programs of this type.

During the past three years, bills for compulsory health insurance have been introduced in a considerable number of states. The majority of these bills are identical, or approximately so, with the "model" state bill for health insurance prepared by the American Association for Social Security. In the writer's opinion, only four state bills for compulsory health insurance have thus far been introduced which are sufficiently different to warrant separate examination and discussion. These are the "model" bill of the American Association for Social Security;[2] the bill drawn up in California by the Governor's Committee on Health Insurance and introduced jointly by a considerable number of the members of the legislature;[3] the bill introduced in the New York Assembly in 1939 by Assemblyman Robert F. Wagner, Jr.;[4] and the bill introduced in the Wisconsin Assembly in 1937 and, with a few slight changes, in 1939, by Mr. Andrew Biemiller.[5]

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The opinions expressed in this article are the writer's and are not to be taken as representing the views of the Social Security Board.

[1] S. 1620, 76th Cong., 1st Sess. (1939).

[2] The bill was prepared by the Association in cooperation with leading authorities, including interested practitioners. The drafting of the bill was done principally by Professor Herman A. Gray of the New York University Law School.

[3] Calif. Ass. B. No. 2172, as amended April 14, 1939.

[4] N. Y. Ass. B. No. 2726. Assemblyman Wagner first introduced his health insurance bill in 1938. The 1939 bill differs from the earlier bill in some important respects.

[5] Wis. Ass. B. No. 807A.

These four bills will now be examined in detail. Parenthetically, it may be said that none of them has been enacted and only one—the California bill—received detailed legislative consideration. This bill had the support of the Governor and was actively debated in the legislature. It was defeated in the Assembly by a vote of 48 to 20.

### THE "MODEL" BILL OF THE AMERICAN ASSOCIATION FOR SOCIAL SECURITY

The "model" bill of the American Association for Social Security would establish a state-wide system of compulsory health insurance covering all employees subject to the state's jurisdiction except (a) those engaged at other than manual labor receiving in excess of sixty dollars a week, and (b) farm laborers, and domestic servants in households having less than three servants.

The cost of this system, equivalent to a total of 6% of pay rolls in covered employments, is to be borne jointly by employers, employees and the state. Employers contribute 3½% of wages in the case of employees receiving $20 a week or less, 2½% in the case of employees receiving more than $20 but not exceeding $40 a week, and 1½% in the case of employees receiving over $40 a week. The contributions of employees vary in reverse fashion. Employees receiving less than $20 a week pay 1% of wages, those receiving $20 to $40 a week pay 2%, and those receiving over $40 a week, 3%. These contributions are to be deducted from wages by the employer. It is seen that in each case the total of employer and employee contributions amounts to 4½% of wages and that, on the whole, employers pay slightly higher contributions than employees. The state government is to contribute to the system an amount equal to 1½% of pay rolls.

Three types of benefits are provided: medical, disability and maternity benefits. The first consists of medical services provided in kind; the last two of cash payments.

Medical benefits consist of the services of general practitioners and specialists, laboratory and clinic services, hospital care including nursing service in the hospital, and dental care—the latter being limited to extractions, plastic fillings, prophylactic care and such other services, including restorative work, as may be necessary to correct conditions seriously prejudicial to health. These services, available to both qualified employees and their dependents, are denoted as the "regular" medical benefits. The Health Insurance Commission, at its own discretion and to the extent it deems advisable, may also provide drugs and medicines, nursing service outside the hospital, institutional care for convalescents, eyeglasses, orthopedic and other appliances, and other forms of dental care beyond those included under the "regular" benefits. The Commission may provide these "additional" benefits without charge to insured persons and their dependents, or may require that part of the cost shall be borne by them.

The furnishing of medical benefits begins three months after contributions accrue and become payable. After the system is in operation, an employee is entitled to medical benefits for himself and his dependents if he has had not less than 10 days of employment or voluntary medical insurance within the three months preceding

the day on which he or any dependent requests medical attention. Eligibility continues so long as the employee remains in covered employment. If he leaves covered employment or becomes unemployed, he and his dependents remain qualified for medical benefits for a period equal to one day for every five days of employment or of voluntary medical insurance during the preceding five years.

Certain restrictions are laid down concerning the length of time for which medical care will be provided in any one illness. Hospital care will not be furnished for any one illness or injury for more than 111 days in all, of which the first 21 are to be without charge, the recipient thereafter paying 15% of the cost. With respect to disabling illnesses, employees are entitled to receive general practitioner care and the stipulated dental services for a maximum of 26 weeks in any one illness, but specialist, laboratory and clinic services for not more than 12 weeks. Apparently, there are no restrictions on length of care in non-disabling illnesses. Nor apparently are there any restrictions on the length or amount of care, except hospital care, which dependents may receive so long as the employee remains in covered employment. After leaving covered employment, the period of time for which an employee or his dependents may receive care in connection with any one illness or injury is limited to 26 weeks for general practitioner medical and dental care and 12 weeks for specialist, laboratory and clinic care.

The bill also provides for the payment of cash benefits in the event of disability or maternity.

Cash benefits, payable for each day of wage loss due to disability after a waiting period of five working days, are to be paid at a rate of 50% of the employee's full-time daily wages but with a maximum of $15 a week. The benefit would be increased by an amount equal to 10% of the full-time daily wages but not beyond $3 per week if the employee had a dependent spouse; and 5% of the full-time daily wage but not beyond $1.50 a week, for each dependent child not exceeding three. An employee with a dependent spouse would thus receive a benefit equal to 60% of full-time wages but with a maximum of $18 per week, and one with a dependent spouse and three or more dependent children would receive a benefit equal to 75% of full-time wages but with a maximum of $22.50 a week.

To qualify for these cash benefits, an employee must have had not less than 104 days of employment or of voluntary cash insurance within the 12 months preceding the day on which cash benefits are to commence or not less than 160 such days within the 24 months preceding that day.

The employee would be entitled to cash benefits for a maximum of 156 cumulative days of wage loss within any period of 52 consecutive weeks. When the right to benefits has been exhausted on account of this provision, the employee cannot draw further benefits unless he has had 60 days of employment or of voluntary cash insurance subsequent to the termination of his benefits and, in addition, is able to meet the original qualifying conditions.

When an employee becomes unemployed or ceases being engaged in covered

employment, his qualification for benefits remains effective for an extended period equal to one day for every five days of employment or of voluntary cash insurance during the preceding five years. If he becomes disabled during this extended period, he is eligible for benefits on the same basis as an employee who had continued in covered employment.

The furnishing of cash benefits begins six months after the date on which contributions accrue and become payable.

Maternity benefits equal in amount to the benefits payable in disability would be paid to qualified women for six weeks before and six weeks after the birth of a child. To obtain this benefit, the woman must abstain from gainful work during the period for which it is payable and must have had not less than 250 days of employment or of voluntary cash insurance during the two years preceding the day on which the benefit is to commence. This regular maternity benefit is to be payable even though an employee has exhausted her rights to cash disability benefits and receipt of the former benefit does not exhaust her rights to the latter. A woman employee who becomes unemployed or leaves covered employment remains qualified for maternity benefits on the same basis as for disability benefits.

An added maternity benefit of $15, payable on the birth of the child, is also given on condition that proper prenatal care shall have been received. This added benefit would be payable to a qualified woman employee, to the wife of a qualified employee, or the widow of such employee providing the child be born within 10 months of his death.

It will be remembered that contributions aggregate 6% of covered pay rolls. Of the funds thus raised, three fourths are earmarked for provision of medical care and the remaining one fourth (*i.e.*, 1½% of pay rolls) is to be used to pay the disability and maternity benefits.

Systems of voluntary disability and medical care insurance are set up for persons with limited incomes who are not covered by the compulsory system. Employees in noncovered employments whose wages are $60 a week or less, and who have not reached 65 years of age, are entitled to subscribe for voluntary cash disability and maternity benefits. Such persons pay contributions equal to 1⅛% of their wages and may receive in return the same disability and maternity benefits as compulsorily insured persons, and under the same provisions with respect to qualifications, waiting period, duration of benefits, etc. Employees voluntarily subscribing to disability and maternity benefits may be required to pass a health examination; however, no examination is to be required of any person who, within the preceding three years, has had not less than 260 days of covered employment or of voluntary cash insurance.

On a somewhat similar basis, a system of voluntary insurance for provision of medical care is established. This system is open to self-employed persons, not merely to those working as employees as in the case of the voluntary disability and maternity benefit insurance. Entitled to subscribe to this insurance are any residents of the state whose net income from whatever source is $60 a week or less, or whose net income

does not exceed $100 a week, provided they have had within the three preceding years not less than 260 days of covered employment or of voluntary medical insurance. Persons also may subscribe, regardless of income, who are at the time unemployed but who have had not less than 260 days of covered employment or voluntary medical insurance within the preceding three years. Voluntary subscribers pay contributions equal to 3⅜% of their income—in the case of unemployed persons, 3⅜% of average weekly income during the preceding three years. Eligible also are any residents receiving old-age or unemployment benefits, or relief, from any governmental or public agency. Each such agency may insure their beneficiaries by paying such amounts as the Commission may fix.

Those taking out this voluntary medical insurance and their dependents are entitled to medical benefits on the same basis as compulsorily insured persons and their dependents.

These voluntary insurances are subsidized to the same extent as the compulsory system, *i.e.*, the state is to contribute amounts equal to one third of the aggregate contributions paid by voluntarily insured persons.

For an additional premium, the Commission may provide additional medical benefits to voluntary subscribers. The premium for these additional benefits is to be fixed so that the persons desiring them will pay the full cost of these benefits.

The health insurance system is to be administered by a "Health Insurance Commission" composed of five persons: the Commissioner of Health Insurance, the State Commissioner of Health, and one representative each of employers, of employees, and of the professions engaged in furnishing the medical benefits. The Commission is to be advised by a State General Advisory Council representative of employers, employees, the public and the professions rendering service, and in addition by a State Medical Advisory Council representative of the main professions or groups concerned with the provision of medical care.

The bill does not specify closely the arrangements for the provision of medical care. It is specified that all duly qualified *general* medical and dental practitioners are to be entitled to render services under the system, and that insured persons are to be free to choose from amongst the participating practitioners in each locality, the physicians or dentists by whom they wish to be attended. General medical and dental practitioners may be remunerated in several ways: by salary, by a per capita payment for each person on their list, by fee, or by any combination of these. No mode for remunerating these practitioners shall be adopted for any local area without the consent of a majority of the general medical and dental practitioners furnishing insurance services in that area.

With respect to the provision of specialist services, nursing care, hospital care, laboratory services, etc., no precise arrangements are stipulated and each local council, subject to the supervision, direction, control and approval of the Commission, may furnish these services through such arrangements as it deems best.

The Commission is required to divide the state into a number of health insurance

districts, each with its district financial supervisor and district medical supervisor—the latter a physician. In turn each district is to be divided into a number of local areas, each managed by a local finance manager, and a local medical manager who must be a physician. Each local area is to have a local council composed of the local finance manager, the local medical manager, the local public health officer, one representative of the professions furnishing medical benefits, one representative of employers, and two representatives of employees. Each local council may appoint, with the advice and consent of the Commission, such local advisory committees as it deems necessary. The local councils, under the direction and subject to the review, approval and control of the Commission, shall supervise and direct the payment of disability and maternity benefits and the furnishing of medical benefits.

## THE CALIFORNIA BILL

The California bill[6] has two distinctive features which may be remarked upon at the outset. First, being drafted after the Wagner National Health Bill had been introduced, it was designed so as to take advantage of federal aid under the terms of that bill. Secondly, since California has a functioning system of unemployment compensation, the drafters of this bill faced the concrete and practical problems of coordinating the projected health insurance system, particularly on its cash benefit side, with the existing unemployment compensation system. Whereas the "model" bill had to be general in order to be a model, the California bill represents an attempt to establish a health insurance system coordinated with the particular unemployment insurance system of a particular state.

The bill amends the State Unemployment Reserves Act so as to establish a "system of social insurance, consisting of unemployment and health insurance." The health insurance system embraces both "disability unemployment" and "medical" benefits, and the bill provides that one part of the system is not to be operative without the other. However, the medical benefit part of the system covers a wider population than the disability unemployment benefit plan and, administratively, the former is set up pretty much as a separate unit while the latter is conjoined with the unemployment compensation system. Accordingly, an understanding of the projected health insurance system may best be gained by considering its two parts separately.

The medical benefit part of the system embraces all employees within the state, including state and local government employees, domestic servants, farm laborers and those of high incomes. (The unemployment compensation system excludes domestic servants, farm laborers and employees working for employers with less than 4 workers, as well as a number of other numerically less important occupational groups.) Employees contribute 1% of taxable wages, employers 1% and the state 1%. In each case, taxable wages do not include that part of an individual's remuneration in excess of $3,000 a year. The amount contributed by the state is to be reduced by any amount received as federal aid from the federal government.

[6] All the following relates to the amended (April 14, 1939) draft of the bill.

Medical benefits—available to the covered employee and his dependents[7]—are of two kinds: "service benefits" and "reimbursement benefits." The first are provided to those earning less than, the second to those earning more than $3,000 a year. Service benefits consist of general practitioner care; stipulated specialist services to the extent permitted by the financial resources of the fund, but in any event to include major surgery, emergency specialist and obstetrical service; laboratory and X-ray diagnostic services; hospitalization up to a maximum of 12 weeks in any year for any one illness; and all drugs and medicines. In addition, nursing care and certain limited dental services are to be provided to the extent permitted by the funds available, and after these services are provided other additional services may be furnished as funds permit.

Reimbursement benefits consist of cash payments to eligible persons in reimbursement of expenditures for medical services. (Presumably the idea of such benefit is that physicians would object to serving persons with incomes over $3,000 on the same basis and for the same fees as those with incomes under this figure. Under this arrangement, physicians would be free to charge persons with incomes over $3,000 such fees as were mutually agreeable and the insured person would be reimbursed for part of this cost.) The bill does not specify closely how the medical reimbursement plan is to operate, but leaves it to the governing authority to work it out. Claims for reimbursement benefits are to be filed and such claims allowed in accordance with a prescribed fee schedule. If the total claims in a period exceed the amount set aside for reimbursement benefits, all claims are to be prorated equally. The total funds available for medical benefits are to be apportioned between service benefits and reimbursement benefits on the basis of the number of insured persons eligible to each.[8]

The provisions for determining eligibility for medical benefits are clear. To be eligible for medical benefits in any given "benefit" year, which runs from July 1 to June 30, an individual must have earned at least $300 in covered employments during the applicable base period, which is the preceding calendar year. In other words, an individual would be eligible for medical care during the period of, say, July 1, 1941, to June 30, 1942, if he had earned $300 or more in covered employments in the calendar year 1940. He would continue to be eligible during the next "benefit" year if he had earned $300 or more in 1941.

The bill provides that a system of voluntary insurance may be established for self-employed persons earning less than $3,000 a year. Voluntarily insured persons are to be entitled to the same service benefits as those compulsorily insured. The rates which they are to pay are to be determined by the governing authority. Persons over 50 would not be eligible to insure voluntarily on an individual basis but such persons may enroll on a group basis. The voluntary system would be subsidized as in the

[7] "Dependents" are defined to include only the dependent spouse and dependent children under the age of 21.

[8] I presume this is the intention; the formula set forth in the bill is obscure.

case of the compulsory system—the state contributing amounts equal to 1% of the earnings of voluntary subscribers.

With respect to the arrangements for the provision of medical care, the apparent intention of the bill is that general practitioner service should be rendered through an open panel system, *i.e.*, patients would have free choice of physician for general practitioner service, and all qualified physicians would be eligible to participate. For these services, physicians are to be paid on a per capita basis, *i.e.*, a fixed amount for each person for whose care they have assumed responsibility. In addition to, or possibly in conflict with, the above, the medical director is given express authority to employ a salaried medical service for any part of the state when necessary for securing the rendition of service benefits.

Specialist and consultant services are to be provided in public diagnostic centers to be organized throughout the state as adjuncts to public hospitals. Such services may also be rendered in approved private diagnostic centers coordinated with approved private hospitals. There is no stipulation of "free choice" as regards specialist services. Both public and approved private hospitals may be utilized, private hospitals being compensated at stipulated rates comparable to the costs of efficiently operated public facilities.

The bill gives encouragement to the development of group practice of medicine by providing that any beneficiary may choose a non-profit group of physicians practicing on a group practice basis. Such a group is to be paid on the basis of a fixed amount per annum for each individual upon its list, the amount of such remuneration to be dependent upon the scope of the medical services rendered.

The medical care insurance plan is to be administered by a Bureau of Medical Service established in a projected "Division of Social Insurance" in a state "Department of Social Insurance and Employment Service." A single agency within this Department is to collect the contributions, maintain the records and do the disbursing for unemployment benefits, disability unemployment benefits and medical benefits. The head of the Bureau of Medical Service must be a physician; he is appointed by the governing authority of the "Department" with the approval of the Advisory Council.

Much authority is given to an Advisory Council to be composed of 8 members appointed by the Governor, three of whom are to represent labor, two employers, and one each the physicians giving service, the Department of Health and the medical schools, respectively. All basic policies must have the approval of the Council.

So much as regards the medical care insurance plan.

The bill provides for "disability unemployment benefits" to be payable at the same rate as unemployment benefits under the state unemployment compensation system. The waiting period for these benefits is to be one week and their duration and the conditions of eligibility for them are to be the same as for unemployment compensation benefits. The coverage for the two types of benefits is the same and the funds for payment of disability unemployment benefits are obtained by diversion of the

present 1% of wages which employees in California now pay for unemployment insurance to a special disability unemployment benefit account. Essentially, disability unemployment benefits are provided through expansion of the existing unemployment compensation system, the Bureau of Medical Service being responsible for certification of disability.

### THE WAGNER-NEW YORK BILL

In drafting this bill, Assemblyman Wagner drew heavily upon the "model" bill of the American Association for Social Security. Many provisions of the two bills are alike and in some places the language is identical. The Wagner-New York bill is very much shorter than the "model" bill, this brevity being obtained to a considerable extent by leaving details to administrative discretion.

The health insurance system set up by this bill applies to all employees excepting those engaged in nonmanual work earning over $2,500 a year. The contributions from employers and employees are identical with those in the "model" bill. However, the state's contribution is to be equal to only 1% of taxable wages (making the total revenues of the system 5½% of wages) and is to be reduced by the amount of any aid received from the federal government.

Both medical and disability benefits are provided. Medical benefits consist of the services of general practitioners and specialists, laboratory and clinic service, hospital care and certain limited types of dental care. These services are available both to the insured person and his dependents. To be eligible for them, the employee must have had 100 days of covered employment or voluntary medical insurance within the 12 months, or 150 days within the 24 months, preceding the day on which the furnishing of medical benefits is asked for himself or his dependents. Care is furnished without time limit so long as the person through whose eligibility they are granted remains insured for such benefit.

Cash benefits are to be paid to compensate for wages lost on account of disability at the rate of 50% of full-time wages with a maximum of $20 a week. This benefit is to be increased by an additional 10% of full-time wages up to $5 a week for a dependent spouse, and an additional 5% of the employee's full-time wages up to a maximum of $3 a week for each dependent child not exceeding four. Such cash benefit is to be payable for a maximum of 156 accumulated days of loss due to disability in each consecutive 52 weeks. The qualifications for this benefit are approximately the same as those of the "model" bill, with the difference that during the so-called extended period of qualification the employee remains entitled to benefits at half rate.

Cash maternity benefits are to be paid to a woman employee for 6 weeks prior and 6 weeks after the birth of a child, in amounts equal to the cash disability benefit to which the employee would be entitled. The qualifying and other conditions for receipt of this benefit are approximately the same as in the "model" bill.

Persons not covered by the compulsory plan are entitled to insure voluntarily for either cash or medical benefits or both, in accordance with conditions formulated by

the Board. Such persons are to be required to pay four fifths of the appropriate contribution for their insurance, and the state is to pay the remaining one fifth. In other words, the voluntary system is to be subsidized by the state to the extent of 20%.

The system is to be administered by a Health Insurance Board of five members, established as a division in the State Department of Health. The members of the Board are to be appointed by the Governor, and at least two must be physicians. As in the case of the "model" bill, provision is made for state general and medical advisory councils.

The bill stipulates that there is to be "free choice" of physician and dentist for general practitioner service. Similar specifications are not made with respect to specialists' care. Physicians may be remunerated by salary, by fee for service, or by per capita system or by any combination or modification of these. The Board is to fix in each district the manner of remunerating physicians and dentists for their services, but no mode of remunerating physicians and dentists in general practice is to be adopted for any local area without the consent of the majority of such physicians or such dentists respectively in that locality.

Unlike the "model" bill, no provision is made for apportioning the funds available between medical and cash benefits.

### THE BIEMILLER-WISCONSIN BILL

This bill differs from all the others previously described in that there is no provision for disability benefits; medical care only would be provided.

The system applies to all employees except those engaged in agricultural labor or domestic service (the latter, where the employer has fewer than four persons in such service) and except persons engaged in nonmanual labor who are paid at the rate of more than $60 per week.

Employers and employees alike are to contribute 2% of wages paid or received. There is no contribution from the state. The system would provide general practitioner and specialist service, nursing care, hospital care, drugs and dressings, laboratory and clinic services, optometrist services and emergency dental care. These services would be available alike to insured persons and their dependents.

To be entitled to medical care, an individual must have had at least four weeks of covered employment within the 26 consecutive weeks immediately preceding the day on which health benefits are first provided. The covered person remains eligible so long as he is employed and for 26 weeks after the last week of employment. In no case will health benefits be available to an eligible person for more than 26 weeks in any one illness.

The health insurance system is to be administered by a Health Insurance Division of the State Board of Health. This Division is to function under the supervision and control of the State Health Insurance Council appointed by the Governor and consisting of an equal number of representatives of each of the following: employees, employers, physicians, dentists, optometrists, pharmacists, hospitals and the general

public. The representatives of the professional groups are to be selected from panels proposed by their state associations.

The Health Insurance Division is to be administered by a director appointed by the State Health Insurance Council, and he is to be assisted by a medical officer also appointed by the Health Insurance Council from a panel of six or more physicians proposed by the state medical society.

Insured persons are to have free choice among the physicians—both general practitioners and specialists—dentists and optometrists electing to provide insurance services, and all members of these professional groups are to have the right to furnish services under the health insurance plan.

## SOME PROBLEMS INVOLVED IN FORMULATING HEALTH INSURANCE PLANS

Against the background of these four bills, we may briefly discuss a few of the more important problems in health insurance.

### *Who Should Be Covered Under Compulsory Health Insurance?*

It is assumed that the purpose of health insurance is to provide adequate medical care and to spread the burden of sickness costs. Insurance is made compulsory primarily in order that the whole of the population covered may participate in these benefits. All four of these bills limit compulsory insurance to a part of the population; all of them exclude from compulsory coverage the self-employed, and two of them exclude in addition farm workers and domestic servants. Finally, all except the California bill limit compulsory coverage to manual workers and to nonmanual employees earning less than $2,500 or $3,000 a year.

It may be questioned whether some of these limitations are altogether necessary or desirable. The social problem of medical care is a community problem. It is not limited to persons working for wages or salary. The position of farmers, small shopkeepers, etc., and their dependents, with respect to need for more adequate medical care and protection from medical cost burdens, is more or less the same as that of employed persons. Distinctions with respect to need are not primarily along occupational but along income lines. By their exclusions, these health insurance bills attempt to solve the medical care problem for only a portion of the population.

Presumably, these bills exclude the self-employed and, two of them, domestic and agricultural workers, not because of a desire to do so, but because it is considered impractical or inexpedient to do otherwise—the compelling factors being very much the same as those which resulted in the exclusion of these groups from the federal old-age insurance system. Inclusion of domestic and agricultural workers may be initially inexpedient, but coverage of these workers is possible as is shown by European experience. With respect to the self-employed, the main obstacle to their coverage is the difficulty of collecting contributions geared to income. To include these persons on the same basis as employees would require the collection from them of what would be essentially special flat-rate income taxes earmarked for health insurance. Whether or not such income taxes can be collected from the self-employed of low

income at a reasonable cost and with reasonably accurate accounting and reporting of income, is a question which requires careful study and consideration.

The fundamental factors involved here are very much the same as in old-age insurance. Old age comes to the self-employed as well as to employees, and both groups need insurance protection. Certainly in health insurance and probably in old-age insurance, government contributions are desirable. The self-employed may feel that it is inequitable for them to pay their share of these taxes and also as consumers to bear indirectly some share of the pay-roll taxes on employers, and yet to derive no benefit from these insurances.

There is also the question of whether health insurance should be limited to those with incomes under a given limit, say $3,000. On the one side there is the consideration that the medical profession will strongly desire such a limitation. Also, inclusion of the high income group is by no means as imperative as inclusion of the self-employed of low incomes. On the other side there is the consideration that non-inclusion of this group might have unfortunate consequences for the system as a whole. It might be argued that it is inconsistent with American traditions of equality and democracy to have one medical service for the low or moderate income groups and another for the well-to-do. Also, restriction of health insurance to those under a given income level might give the system an inferiority complex, so to speak—to cause all to believe, whether or not there are any real grounds for such an opinion, that insurance medical care is never quite as good as the service obtained by the well-to-do under private practice.

*Eligibility Requirements*

The provisions in these health insurance bills with respect to the determination of eligibility for medical care raise complex and important questions. The problems to be faced are these: Assuming the medical insurance system is in current operation, how soon after a person newly enters covered employment do he and his dependents become eligible for medical care? By what procedures is the eligibility of insured persons to be indicated to doctors, hospitals, etc., so that the one may obtain and the other provide service without delays, inconvenience and red tape? Are any restrictions to be set on the volume of service which a covered person may obtain so long as his eligibility continues? If so, how are these to be administered? If a covered person becomes disabled or unemployed or leaves covered employment, for how long do he and his dependents remain eligible for medical care? In the case of such persons, how is the physician to be notified that they are no longer eligible for free care under the insurance plan?

Of the four bills, the California bill seems to contain the least complex provisions on these points. It provides that persons are eligible for medical care during a "benefit year" lasting from July 1 to June 30, if during the preceding calendar year they earned $300 or more in covered employment. Thus, eligibility for care runs in year intervals—the intervals being the same for all workers. During the period of his eligibility, the worker is entitled to medical care without limitations, except with

respect to hospital care, as to volume of service or length of care in any illness. When his year of eligibility is up, he forthwith ceases to be entitled to medical care unless, of course, he has gained eligibility for the new year by having had sufficient earnings in the applicable base period. Under this arrangement it would be possible to provide all persons having the requisite earnings in the base period with cards, good for the ensuing benefit year and for that year only, which would indicate their eligibility to physicians, hospitals, etc.

With these eligibility provisions, it would be possible for the health insurance system to utilize for the determination of eligibility the same employment and wage records which are now obtained from the employer under the unemployment compensation system; one may judge that it was the desirability of this that led to the adoption in the bill of these particular eligibility arrangements. However, while these arrangements seem administratively feasible, the precise requirements laid down have certain undesirable consequences. Thus, a person newly entering covered employment would have to wait six months to almost a year and a half before he would be entitled to medical care. It would seem preferable, if it were administratively possible, to make the period of eligibility for medical care coincide more nearly with the period of covered employment.

The eligibility arrangements in the other three bills follow a quite different pattern than those of the California bill. Under these bills, the worker becomes eligible for medical care soon after entering covered employment (10 days in the "model" bill, 4 weeks in the Biemiller-Wisconsin bill, and 100 days in the Wagner-New York bill), he continues to be eligible as long as he works in covered employment, and upon leaving covered employment he remains eligible for a certain period *which is measured from the last day of his employment.* There is thus a different period of eligibility for each worker. These provisions would require reports from employers quite different from those now common under unemployment compensation. (It might be more desirable for eligibility to run in fixed intervals of time. Then, periodically, lists could be furnished to physicians or cards to insured persons indicating eligibility for a future quarter, half year or year.)

Two of the three bills place certain limitations on the number of weeks for which an eligible worker may obtain medical treatment in any one illness—one of the bills limits duration of medical benefits only in the case of disabling illnesses. Methods would thus have to be devised for keeping track of the number of weeks for which medical care was provided in any one case. Although the administrative problems seem complex, European experience indicates that they can be solved.

In all of this it needs to be remembered that eligibility requirements are important in proportion to the limitations in coverage. If the insurance system is made universal in coverage, eligibility requirements to all practical purposes can be dispensed with. This is desirable because socially the aim of health insurance is to provide medical care.

*Coordination of Disability and Unemployment Benefits*

Temporarily disabled and unemployed workers are suffering the same wage losses and it would seem logical that both should be compensated alike for such losses. Accordingly, it would seem desirable that disability and unemployment benefits should be paid at the same rate and that the waiting periods and eligibility requirements should be the same. However, there are factors in the situation which may make some differences unavoidable. It would also be desirable on some counts to have the benefit duration period the same, though this is complicated by the exigencies of coordinating temporary disability insurance with invalidity insurance, on the one hand, and of coordinating unemployment insurance with work relief or relief on the other.

The California bill compensates disability and unemployment at the same rate, and provides for identical waiting and benefit periods and eligibility requirements. Indeed it goes further and provides for joint administration of disability and unemployment benefits with, however, a separate fund for each. The joint system is then administratively coordinated with the medical care insurance system by placing both within a "Department of Social Insurance and Employment Service," and by providing that the same agency shall collect contributions, maintain accounts and records and disburse for all three benefits.

The other bills follow a different line. The Wisconsin bill does not provide disability benefits. The "model" bill and the Wagner-New York bill both follow European precedents in that they provide for joint administration of medical care and disability benefits. Neither of these bills provide for coordination of disability and unemployment benefits. Indeed, the "model" bill was prepared before there was an unemployment compensation law, except in Wisconsin, and the Wagner-New York bill was written without attempt to take account of New York's unemployment compensation system. It would necessitate employer reports and wage records independent of those now required by that system.

*Coordination or Integration of Health Insurance and Other Governmental Health Services*

It is imperative to coordinate or possibly to integrate health insurance medical services with other governmental health services. In general, it may be said that the wider the population covered by health insurance the greater the desirability of correlating or integrating the system with public health work, provision of care to the indigent, and other public medical services.

All of these health insurance bills provide in various degrees for the coordination of their limited coverage systems of health insurance with public health activities. The "model" bill does this by making the health commissioner a member of the Health Insurance Commission; the California bill by making the health commissioner a member of the all-important Advisory Council. The Wagner-New York and Biemiller-Wisconsin bills go further and set up the health insurance system as a division within the state board of health.

None of the four bills makes mandatory the coordination of insurance medical services and services for the indigent. The "model" and Wagner-New York bills, however, do provide that public unemployment and relief agencies may insure their clients for medical care by paying the appropriate premium.

There are excellent reasons for integrating the provision of medical services to insured and indigent persons so that both groups are served by the same physicians and facilities. This can be achieved by having the appropriate governmental agency insure the indigent under the health insurance system by paying the contributions on their behalf. To do otherwise—to have separate systems for the poor and for the self-supporting, with each group served by more or less different sets of physicians, would have many obvious disadvantages.

*Organization for the Provision of Medical Care*

The correction of the present lacks and inadequacies in our national medical care situation may be said to involve two main problems: first, that of fashioning a system of payment for medical care which will enable people to purchase the service they need at a cost they can afford; and second, that of fashioning arrangements for the provision of care which will assure high standards of quality of service and the delivery of service efficiently and at reasonable cost. The two problems, of course, interlock.

What is rapidly becoming a voluminous literature attests to a growing opinion to the effect that the individual physician practicing by himself labors under handicaps in the provision of adequate care. The growth of medical knowledge has necessitated the development of specialism. The provision of an integrated service to the patient is held to require the coordination of the service of specialists and of general practitioners and specialists through organization. Thus, the primary recommendation of the majority of the Committee on the Costs of Medical Care was that "medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists and other associated personnel. Such groups should be organized preferably around a hospital for rendering complete home, office and hospital care. . . ."[9] Recently, the Committee of Physicians for the Improvement of Medical Care, in giving its views with respect to the Wagner National Health Bill, stated as a general principle, which should be incorporated in any such legislation, that "Complete medical services, including prevention, are no longer obtainable through the individual practitioner alone. The rapid development of modern medical science has made it impossible for the individual doctor to provide all the facilities needed for modern scientific medical care. Good medical care now requires the integrated service of the individual doctor, the laboratory and the hospital."[10]

How do these health insurance bills propose that medical care shall be provided? How is the provision of medical care to be organized? All of the bills under con-

[9] MEDICAL CARE FOR THE AMERICAN PEOPLE (1932) 109.

[10] Proposals for Amendment of the Wagner Bill S. 1620, Hearings before a Subcommittee of the Senate Committee on Labor and Education, on S. 1620, 76th Cong., 1st Sess. (1939) 951, 955.

sideration are content to handle this problem in terms of broad principle. They do not go into details. One finds no detailed blue prints as to how the system is to be administered on the ground.

All four bills stipulate that every insured person is to have the right to select the physician from whom he wishes to receive *general practitioner* care from among the physicians in each locality or area who have signified their willingness to render this service under the insurance plan;[11] and that every qualified physician shall have the right to participate in the provision of *this type of service* to insured persons, provided he agrees to accept remuneration at the stipulated rates and to abide by the other necessary conditions of the plan. This would mean that every insured person could continue to have the same family physician or general practitioner, as at present, provided his physician wishes to give service under the insurance plan. Thus, for general practitioner care, a "free choice" open panel system is stipulated.

The "model" and Wagner-New York bills provide that physicians rendering general practitioner care may be remunerated in any of the following ways: (a) by salary, (b) by a fixed payment per quarter or year for each insured person on their lists, *i.e.*, for whose care the physician assumes responsibility, and (c) by a fee system, or (d) by any combination of these methods. Both bills also provide that no method of remuneration for general practitioner service shall be adopted for any locality or area which does not have the approval of a majority of the physicians in that area giving this service.

The Biemiller-Wisconsin bill restricts the mode of remuneration of general practitioners to a per capita or fee system or any suitable combination of these two. The California bill, aside from stipulating that patients shall have free choice of general practitioners and that all qualified physicians shall be entitled to provide this type of service, does not specify the mode of remuneration.

All of the above concerns simply general practitioner service. As regards the provision of specialist services, the "model" and Wagner-New York bills leave the matter open, *i.e.*, they do not stipulate "free choice" and they give the administrative authority *carte blanche* to organize such services as it finds best. The California bill, provides that specialist and consultant services are to be rendered by public and approved private diagnostic centers, the services of which are to be coordinated with public or approved private hospitals. In addition, it stipulates that insured persons, when entitled to choice, may choose any nonprofit group practice unit of physicians on the same basis as an individual physician. The Biemiller-Wisconsin bill makes the greatest concession to expediency. It provides for a "free choice" panel system for specialist as well as for general practitioner service.

Thus, of the four bills, only the California bill stipulates that medical service shall be provided through group practice units—and this only as regards specialist services. The "model" and Wagner-New York bills would permit the health insurance

[11] The "model" and Wagner-New York bills also stipulate free choice for general practitioner dental services.

authorities to develop group practice arrangements for the provision of specialist care, but do not require this.

An open panel system, as is stipulated by all four bills for general practitioner care and by the Biemiller-Wisconsin bill for specialist service, does not in itself provide any certain guide as to whether insurance medical practice would be primarily *individual* practice or *group* practice. It leaves the question up to the physicians themselves. If they wish to practice *solo* they can do so; if they should wish to come together into group practice units, they can do so. As physicians learn the technique of group practice and as they become familiar with its professional advantages and financial economies, group practice may be expected to develop of its own accord under insurance, just as it has developed to a certain extent under private practice of the present day.

Is compulsory health insurance likely to "freeze" the individual private practice of medicine and retard the development of group practice? One may venture to think not.

It seems probable that we must solve our problems one at a time and build on what we have. The solution of the "payment" problem through health insurance will be a great step forward, and one which should lead toward the evolution and development of group practice. Presumably under health insurance, a central authority is created which, on behalf of the insured population, is interested in seeing that the quality of service delivered is as good as possible, and that care is provided as economically and efficiently as possible. Under such a system, interests now diffused and scattered are concentrated and can thus be made effective. Given this situation, comparisons of the quality and cost of medical service under group and individual practice will have an obvious moral.

# SOME PROBLEMS IN THE FORMULATION OF A DISABILITY INSURANCE PROGRAM

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In modern society, as in earlier times, the family remains the basic economic unit, but the ways in which a family obtains its livelihood have been greatly altered. In a nonindustrial society almost every member, excluding infants and very young children, can contribute to the family economy. In an industrial society the process of earning a living engages the activities of only one member or of a very few members of the family. The economic security of nine in every ten American families now depends chiefly on the earnings of one individual. Any serious interruption in his earnings, whether through unemployment, disabling disease, accidental injury, or old age causes economic insecurity, and may precipitate destitution and even disruption of the family.

Conscious of this fundamental change in the methods of earning a living, and appalled by the devastating effects of the depression, the United States has followed the example of other nations in developing social insurance. Measures have already been adopted to mitigate the insecurity attendant upon loss of earnings through old age or unemployment. The workmen's compensation laws, enacted by the federal government for certain groups subject to its jurisdiction and by 47 of the states for workers in various industries and occupations, provide insurance against disability

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resulting from employment. Hence, a considerable proportion of the working population of the country now has some protection against the risks of old age, unemployment, and industrial disabilities. No extensive provisions have, however, been made to protect workers against interruption of earnings brought about by disabling diseases and non-industrial accidents. This is a serious gap in the bulwarks against insecurity because in our industrial economy disability is one of the major causes of interruption of earnings.

The National Health Program, developed by the Technical Committee on Medical Care (a subcommittee of the President's Interdepartmental Committee to Coordinate Health and Welfare Activities) included proposals for social insurance against disability. Among the four broad recommendations submitted by the Interdepartmental Committee in its report of January 12, 1939, to the President,[1] was the following:

D. The committee recommends the development of social insurance to insure partial replacement of wages during temporary or permanent disability.

The committee indicated its belief that insurance against temporary disability should be established through federal-state cooperative arrangements, and that insurance against permanent disability should be effected through liberalization of the federal old-age insurance system, so that benefits would become payable at any time prior to age 65 to qualified workers who become permanently and totally disabled.

In bringing into legislative form the recommendations of the Interdepartmental and Technical Committees, Senator Wagner divided the disability proposals. The basis for a federal-state system of temporary disability insurance was provided through Title XIV of his proposed "National Health Act of 1939," S. 1620. The expansion of the federal system of old-age insurance to furnish permanent and total disability (invalidity) benefits was proposed[2] through an amendment to H. R. 6635, which eventually became the "Social Security Act Amendments of 1939."

Neither S. 1620 nor the disability amendments to H. R. 6635 were enacted. However, in the Preliminary Report on S. 1620 to the Senate from the Committee on Education and Labor, Senator Murray, chairman of the subcommittee which had conducted the hearings on this bill, said:

The committee . . . cannot ignore the problems created by permanent disability when it studies measures to deal with temporary disability, despite the fact that proposals for permanent disability benefits were not specifically included in the bill under consideration. A system for permanent disability compensation must be reasonably related to old-age insurance, and such a system has been under consideration by another committee of the Senate studying amendments to title II (old-age insurance) of the Social Security Act. Developments in this field and the need for permanent-disability compensation legislation will be considered carefully by our committee in connection with title XIV of S. 1620.[3]

Taken together, Title XIV of S. 1620 and the proposed amendments to H. R. 6635 constitute a logical pattern for the development of social insurance against loss of

[1] H. R. Doc. No. 120, 76th Cong., 1st Sess. p. 16.

[2] *Social Security Act Amendments:* Hearings before the Sen. Committee on Finance, on H. R. 6635 (revised, 1939) 76th Cong., 1st Sess., pp. 296-305.

[3] S. REP. No. 1139, 76th Cong., 1st Sess., p. 23.

earnings by reason of disability. Other patterns are, however, possible and defensible and deserve careful consideration.

This paper is primarily concerned with underlying characteristics of disability problems and with some of the considerations which should be weighed and examined in the formulation of a disability insurance program. A brief review of fundamental facts concerning the incidence and the prevalence of disability, and the economic consequences of disablement, will furnish a background for these considerations.

## THE NEED FOR DISABILITY INSURANCE

The need for disability insurance may be shown by (a) the amount of dependency traceable to disabling illness, and (b) the wage losses due to disabling illness, their distribution, and the magnitude of such losses in relation to earnings.

*Dependency Caused by Disability.* The proportion of dependency attributable to disabling illness varies from time to time, the relative importance of disability as a cause of dependency being greater in years of prosperity, when there is little unemployment, than in years of severe depression, when there is much unemployment. In 1919 the Ohio Health and Old Age Insurance Commission reported:[4]

> For the United States the consensus of opinions from all responsible sources is that from 35 per cent to 50 per cent of the poverty which asks for relief is directly due to sickness. As the result of an investigation covering forty-three cities and over 30,000 charity cases, the United States Immigration Commission reported in 1909 that illness of the breadwinner or other member of the family was a factor in 38.3 per cent of the cases seeking aid. In New York City, "sickness or deformity" were present in two-thirds of the 3,000 families assisted by the Charity Organization Society in the first five months of 1916; in Chicago sickness is reported as the primary factor in 25 per cent of the cases cared for in 1917 by the United Charities, and as a contributory factor in 45 per cent of the other cases; in San Francisco and Los Angeles sickness was the primary cause of destitution in 50 per cent of over 5,000 charitable cases.
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> For Ohio, the investigations made for the Commission show that sickness is the leading cause of dependency. In Cleveland, the Associated Charities reports that in 1917, 51 per cent of their cases were due to sickness; Columbus reports 25 per cent of the applications are due directly to sickness and that sickness is present in 74 per cent of cases; Newark, 36 per cent; Springfield, 30 per cent and Toledo, 35 per cent. In Cleveland, an examination covering a three year period of the Associated Charities' records was made for the purpose of determining the proportion of disability, other than that due to industrial accident, present among those applying the first time for relief. The results showed that out of 6,272 cases seeking relief for the first time, disability was present in 2,112 or 33.7 per cent.

The Illinois Health Insurance Commission, in a report submitted in 1919, said:[5]

> Investigations made elsewhere than in Illinois show that disabling sickness may be charged with about a quarter of dependency not cared for in almshouses and similar institutions. The reports made to the Commission by charity organization societies of eight Illinois cities assign sickness as the chief cause of approximately one-third of all dependency

[4] OHIO HEALTH AND OLD AGE INSURANCE COMM'N, HEALTH, HEALTH INSURANCE, OLD AGE PENSIONS (1919) 59-60.

[5] ILL. HEALTH INSURANCE COMM'N REPORT (May 1, 1919) 20.

in 1917-1918. Our investigation of the data provided by Chicago charitable agencies for an eight year period indicates that physical and mental disability is designated in one-third to one-half of all analyzed causes and problems of dependency. The lower dependency ratio ascribed to sickness by other investigators was found to be due to the fact that their studies were made in years abnormal for poverty and dependency by reason of an unusual degree of unemployment.

As these and other reports indicated, in years of normal employment as much as 50% of all dependency could be attributed largely, if not entirely, to disabling disease. In a period of extensive unemployment such as this country has experienced in the last decade, the relative volume of dependency attributable to disabling sickness would be smaller.

Recent statistical (as distinguished from case) studies have not always lent themselves to an unequivocal determination of the relative importance of sickness as a cause and as a consequence of illness. Some of these have, nevertheless, cast considerable light on disability as a cause of dependency.

In 1933, the United States Public Health Service examined the association between disabling disease and change of family income status.[6] The study was based on the illness records for a three-month period in 1933 among 12,000 wage-earning families in eight cities, a group of coal-mining communities, and a group of cotton-mill villages. It was found that the rate of disabling illness was 48% higher among families having no employed wage earners in 1932 than among families having full-time workers. The group of families which had dropped from fairly comfortable circumstances to relief rolls during the depression years showed a rate of disabling illness 73% higher than that of their more fortunate neighbors who had remained in the comfortable class throughout the four-year period. This study gave unmistakable evidence that the sharpest change in income status occurred among families experiencing disabling illness in 1933.

A study made in 1934,[7] based on a house-to-house canvass of more than 165,000 relief families in 79 cities, indicated that 21% of the individuals in these families, in ages 16 and over, reported serious handicaps. Among persons of wage-earning ages, that is 16 to 64, 15% of those seeking work and 27% of those not seeking work were reported as being seriously handicapped. The latter proportion would have been much higher had it been possible to exclude from this class women who were not seeking work because of home duties. In the course of this study, in Dayton, Ohio, where the survey included nonrelief as well as relief families, it was found that the prevalence of disabilities among persons on relief was three times as great as among those not on relief.

An analysis of the relief population of seven Maryland counties in 1934[8] indicated that among persons of wage-earning ages who were working or seeking work 22%

[6] Perrott and Collins, *Relation of Sickness to Income and Income Change in 10 Surveyed Communities* (1935) 50 PUBLIC HEALTH REPORTS, No. 18, pp. 595-622.

[7] Perrott and Griffin, *An Inventory of the Serious Disabilities of the Urban Relief Population* (1936) 14 MILBANK MEMORIAL FUND Q. 213-240.

[8] Manny and Clowes, *An Analysis of the Relief Population in Selected Areas of Maryland,* (Mim. Circ. No. 1, Univ. of Md. Social Research Studies, Aug. 1937).

had serious disabilities. A Michigan study[9] showed that of 192,000 cases on the state's emergency relief rolls at the end of January 1935, over 37,000, or more than 19%, contained no employable individuals.

The National Health Survey demonstrated that among more than 650,000 families in 81 cities the following proportions reported that the head of the family was not gainfully employed or seeking work because of chronic disability:[10]

| *Income status of family* | *Percent* |
|---|---|
| Relief | 5.2 |
| Nonrelief | |
| Under $1,000 | 2.4 |
| $1,000 to $1,999 | 0.8 |
| $2,000 to $2,999 | 0.5 |
| $3,000 and over | 0.4 |

The same study showed that the frequency of illness, especially of chronic illness, was markedly greater in families reporting relief than in families having incomes of $3,000 and over. The incidence of acute disease among relief families was 47% higher than among families with incomes of $3,000 and over, and the incidence of chronic disease 87% higher for the relief families.[11] These discrepancies become even larger if the duration of disability is considered. Regarding days of disablement of individuals in families with incomes of $5,000 and over as 100, the corresponding values for persons aged 15 to 24 in families on relief would be 267, and for ages 25 to 64, 351.[12]

In a study of nearly 50,000 New Jersey cases on relief on November 30, 1937,[13] it was found that more than 25% were families without employable individuals, and in almost half of these families the lack of an employable individual was attributed to disabling disease. In the families with one or more employable members, 7% of the adults were seriously disabled. In New York City, of 158,000 cases accepted for relief during 1938, 15,000 or approximately 10% were persons who had lost their jobs in private industry because of illness.[14]

In interpreting the significance of these statistics, and of many similar reports which could be cited, it should be kept in mind that, in many cases, although a dependent family may have no disabled worker at the time of a canvass, disability may have been the initial link in the chain of events which rendered the family dependent. Although available studies are inconclusive as to the precise proportion of dependency

[9] Mich. State Emergency Welfare Relief Comm'n, *Unemployable Persons on the Emergency Relief Rolls in Michigan* (March 1935).

[10] NATIONAL HEALTH SURVEY: 1935-36, *Illness and Medical Care in Relation to Economic Status*, Sickness and Medical Care Series, Bull. 2, U. S. Pub. Health Service (1938) 3.

[11] *Id.* at 2.

[12] Computed from *id.*, *Disability from Specific Causes in Relation to Economic Status*, Sickness and Medical Care Series, Bull. 9, U. S. Pub. Health Service (1938) 2.

[13] N. J. Financial Assistance Comm'n, *Persons Reported With Chronic Physical Disabilities in the New Jersey Relief Census of November 30, 1937* (June 1939).

[14] Hodson, *Correlating Unemployment Insurance and Home Relief*, SOCIAL SECURITY IN THE UNITED STATES, 1939: A RECORD OF THE TWELFTH NATIONAL CONFERENCE ON SOCIAL SECURITY (Am. Ass'n for Social Security, Inc., 1939) 132-142.

that may be attributed to disabling disease and nonindustrial accident, they indicate quite definitely that even in periods of severe unemployment disabling illness is the cause of a considerable proportion of dependency. When unemployment is less prevalent, disability rises to high rank among the principal causes of dependency.

*Extent of Disability.* A precise statement of the volume and incidence of disability among gainful workers cannot be made from available data, and probably must await the actual operation of a system of disability insurance. Until such time, estimates must be based upon the data that have become available from various sickness surveys and from the experience of private insurance companies, employee or fraternal mutual benefit insurance, public retirement, and disability plans, etc., each of which is limited in scope and in coverage. In comparison with these the disability statistics derived from foreign social insurance experience, with appropriate adjustment and standardization, may offer more dependable guidance.

The most recent and comprehensive sickness study in this country is the National Health Survey conducted by the United States Public Health Service in the winter of 1935-36. This survey consisted of a house-to-house canvass of some 800,000 households, involving 2,800,000 persons in 84 cities distributed among 19 states and in 23 rural counties in 3 states. When the findings of this survey are applied to the population of the United States, it appears that on any day during the winter months about 4.5% of the population, or almost 6 million individuals, are unable to work, attend school, or pursue other usual activities on account of illness, injury, or gross physical impairment resulting from illness, accident, or congenital defects.[15] Although more illness and disability prevails during the winter months of the year, there is, nevertheless, good reason to believe that, large as the above figures are, they materially understate the prevalence of disability on an average day.[16]

Preliminary returns from the same survey indicate that among gainfully employed white persons aged 15 to 64, 2.36% were disabled on the day of the canvass. The prevalence of disability was found to be considerably greater among unemployed than among employed individuals, and greater among females than among males. Thus, it was found that 3.95% of the unemployed were disabled on the day of the canvass, as compared with 1.95% of those who held jobs; and that 2.20% of male gainful workers were disabled, as compared with 2.77% of female workers.[17] The prevalence figures of the National Health Survey indicate that gainful workers in ages 15 to 64 average 8.6 days of disability per year; for males the figure is 8.0, and for females 10.1.[18]

If these figures were used to anticipate the volume of disability to be expected under an insurance system, they would be too low for at least two reasons, even

[15] NATIONAL HEALTH SURVEY: 1935-36, *An Estimate of the Amount of Disabling Illness in the Country as a Whole*, Sickness and Medical Care Series, Bull. 1, U. S. Pub. Health Service (1938) 1.

[16] This understatement results from the underreporting and exclusion of certain categories of disabled persons, such as persons in mental hospitals, and from underenumeration inherent in a canvass of this type.

[17] NATIONAL HEALTH SURVEY: 1935-36, *Illness Among Employed and Unemployed Workers*, Sickness and Medical Care Series, Bull. 7, U. S. Pub. Health Service (1938) 3.

[18] Computed from NATIONAL HEALTH SURVEY: 1935-36, *supra* note 17.

assuming that the reporting were complete: (1) In the absence of insurance compensation many workers who are ill and who ought not be at work continue working because of economic pressure; and (2) disabled persons who have been out of the labor market for some time because of their disability will not ordinarily be included in the statistics of gainful workers.

That the extent of disabling illness, among those who are or who have been gainfully employed workers, is appreciably greater than the crude averages derived from the National Health Survey is indicated by various insurance experiences, domestic and foreign. Thus, in 1927 the study of a sample population covered under the British National Health Insurance indicated that insured workers averaged 14.6 compensable days of incapacity during a year.[19] When this figure is adjusted to allow for the volume of incapacity incurred within the three-day waiting period, the average amount of disability experienced under the National Health Insurance is approximately 15.6 days. It should be remembered, however, that the National Health Insurance is limited to manual workers and to nonmanual workers with incomes of less than £250 a year. Since the volume of disability is relatively large among low income groups, it is probable that the volume of sickness experienced among the gainfully employed in the United States is somewhat less than that shown by this British experience.

In Scotland, the average annual per capita number of compensable days of incapacity has been as follows among persons covered by the National Health Insurance:

| Year (July 1-June 30) | Days of incapacity[1] (including influenza) | Days of incapacity[2] (excluding influenza) |
|---|---|---|
| 1930-1 | 10.1 | 9.2 |
| 1931-2 | 9.9 | 8.8 |
| 1932-3 | 10.9 | 9.5 |
| 1933-4 | 10.0 | 9.9 |
| 1934-5 | 10.9 | 10.6 |
| 1935-6 | 11.4 | 11.2 |
| 1936-7 | 14.9 | 10.9 |

[1] DEP'T OF HEALTH FOR SCOTLAND, ANNUAL REPORTS ON INCAPACITATING SICKNESS IN THE INSURED POPULATION OF SCOTLAND, I-VII, JULY 1, 1930 TO JUNE 30, 1937 (1932-1939).

[2] *Id.* VII, JULY 1, 1936 TO JUNE 30, 1937 (1939) table B, p. 7.

Again, these averages would have to be increased by about one day per capita per annum, to take account of the three-day waiting period.

The German workers' insurance experience[20] shows a much higher volume of compensable disability, namely, an average of 28.3 days per insured worker in 1933, and when allowance for the three-day waiting period is made this figure becomes

[19] Calculated from data given by Watson, *The Analysis of a Sickness Experience* (1931) 62 J. OF THE INST. OF ACTUARIES, pt. 1, pp. 12-61.

[20] Adjusted for the age and sex proportions of the U. S. old-age insurance population with wage credits recorded for 1937. When the British experience cited above is similarly adjusted, the average amount of disability is increased from 15.6 days per capita per annum by approximately 0.5.

about 29.3. This greater volume is partly to be explained in terms of the much more liberal benefit formulas of the German sickness and invalidity insurance systems, the effects of the World War, and the fact that this average applies exclusively to manual workers. (Salaried workers are covered in a separate insurance system.) Again, these figures include temporary and permanent compensable disability among those who have dropped out of the labor market as well as those who are still among the gainfully employed.

On the basis of foreign experience and data available in the United States, it may be estimated that the average annual volume of disability for gainful workers in the United States may be as much as about 12 days per person. On this basis, the total loss in wages incurred would be more than one billion dollars in a year of moderate unemployment. This loss is all the more serious because it falls on a relatively small number of families in any year. This is illustrated by the figures given in the following tabulation, showing the distribution of disabilities lasting 8 days or more among 60,000 white male railroad employees.

NUMBER AND PERCENT DISTRIBUTION OF DISABILITY CASES AND OF VOLUME OF DISABILITY, BY DURATION. EXPERIENCE BASED ON DISABILITY LASTING EIGHT DAYS OR MORE AMONG 60,000 WHITE MALE RAILROAD EMPLOYEES, 1930-1934 INCLUSIVE.[1]

| Duration | Number of Cases Per 1,000 Exposed | | Percent of Disabled Cases | | Number of Days of Disability Per 1,000 Exposed | | Percent of Total Days of Disability | |
|---|---|---|---|---|---|---|---|---|
| | Specified duration | Specified and longer duration | Specified duration | Specified and longer duration | Specified duration | Specified and longer duration | Specified duration | Specified and longer duration |
| 8-14 days..... | 40.81 | 131.46 | 31.0 | 100.0 | 464.37 | 9,750.84 | 4.8 | 100.0 |
| 15-28 days..... | 36.67 | 90.65 | 27.9 | 69.0 | 761.81 | 9,286.47 | 7.8 | 95.2 |
| 29-49 days..... | 20.18 | 53.98 | 15.4 | 41.1 | 768.90 | 8,524.66 | 7.9 | 87.4 |
| 50-70 days..... | 9.23 | 33.80 | 7.0 | 25.7 | 548,04 | 7,755.76 | 5.6 | 79.5 |
| 71-91 days..... | 5.26 | 24.57 | 4.0 | 18.7 | 426.20 | 7,207.72 | 4.4 | 73.9 |
| 13-26 weeks... | 8.95 | 19.31 | 6.8 | 14.7 | 1,110.68 | 6,781.52 | 11.4 | 69.5 |
| 26-39 weeks... | 2.86 | 10.36 | 2.2 | 7.9 | 633.44 | 5,670.84 | 6.5 | 58.1 |
| 39-52 weeks... | 1.88 | 7.50 | 1.4 | 5.7 | 602.64 | 5,037.40 | 6.2 | 51.6 |
| 1- 2 years.... | 3.08 | 5.62 | 2.3 | 4.3 | 1,527.28 | 4,434.76 | 15.6 | 45.4 |
| 2- 3 years.... | 1.31 | 2.54 | 1.0 | 2.0 | 1,186.05 | 2,907.48 | 12.2 | 29.8 |
| 3- 4 years.... | 0.77 | 1.23 | 0.6 | 1.0 | 977.09 | 1,721.43 | 10.0 | 17.6 |
| 4- 5 years.... | 0.46 | 0.46 | 0.4 | 0.4 | 744.34 | 744.34 | 7.6 | 7.6 |
| Total..... | 131.46 | .... | 100.0 | ... | 9,750.84 | ..... | 100.0 | .... |

[1]Based on data from Gafafer, *Frequency of Sickness and Nonindustrial Accidents Causing Disability Lasting Eight Calendar Days or Longer Among 60,000 White Male Railroad Employees, 1930-34, Inclusive* (1938) 53 PUBLIC HEALTH REPORTS, No. 15, pp. 555-573.

Of the total number of disabling cases, exclusive of cases lasting one week or less, at one extreme almost one third involved disability lasting 8 to 14 days, and these cases accounted for only 4.8% of all disability. At the other extreme, 4.3% of the cases involved disabilities lasting a year or longer and accounted for 45.4% of all disability.

In an average year, while a large proportion of families may suffer little or no loss of earnings from disability, about 10-20% may suffer losses that are substantial.

In each year about 1% of the families may permanently lose the earnings of their chief breadwinner. Thus, a large part of the annual wage loss due to disability will be borne by a small part of the population. Because the rates of disability are higher the lower the income level, the burden falls most heavily on those least able to bear it. In the cases most seriously affected, the losses are frequently large enough to wipe out whatever savings the family may have and in many instances large enough to carry them below the level of self-support. This is illustrated by preliminary results obtained from a study of family composition in the United States which indicate that approximately 50% of families in which the head was not seeking employment because of disability were on relief.[21]

In Europe, because of earlier industrialization and the relatively lower incomes of the working population, the need for protective measures against disabling disease became evident sooner than in the United States. In the nineteenth century wage earners banded together through fraternal societies, lodges, unions, and other mutual assistance organizations to provide themselves with insurance protection against sickness and invalidity. Valuable as these voluntary systems were, they proved inadequate to cope with the problem, and gradually one nation after another adopted compulsory insurance to provide compensation for disability. Today, some 32 nations have compulsory systems of sickness and invalidity insurance covering at least all or almost all the manual workers.[22] Of the nations which now have insurance against sickness and invalidity, 21 have both, 6 have insurance against invalidity only, and 6 have insurance against sickness only.

In the United States, there is some voluntary insurance against disability. It is estimated that almost 8 million wage earners possess some form of insurance against temporary disability; however, for a large proportion of these workers the protection afforded by such insurance is very slight. It is estimated that about 20 million wage earners possess some form of insurance against invalidity; but 15 million of these are workers holding industrial insurance, and most of their policies are so restricted in scope as to provide no substantial protection.[23] The vast majority of employed persons in this country have no real or substantial protection against the risk of loss of earnings from disability. The experience of foreign countries indicates that there is little likelihood that the situation will be fundamentally altered in the future unless governmental action is taken to make broader and more substantial insurance protection available to gainfully occupied workers.

### THE PROBLEM OF DISTINGUISHING TEMPORARY DISABILITY AND INVALIDITY

In formulating a program of disability insurance the first question is to decide whether one program should be adopted for all disability cases or whether two pro-

[21] Sanders, *Family Composition in the United States* (1939) 2 SOCIAL SECURITY BULL. No. 4, pp. 9-13.

[22] A considerable number of other countries have temporary disability and invalidity insurance covering various segments of their working population. These, however, have been excluded from the count given above, which includes only countries where the coverage is extended at least to all or almost all the manual workers.

[23] Otey, *Cash Benefits Under Voluntary Disability Insurance* (1939) 2 SOCIAL SECURITY BULL. No. 2, pp. 27-33.

grams should be evolved, one for short-time disabilities and the other for disabilities of long duration or of a permanent character.

In general, cases of disability may be classified in three types. At the one extreme, there is temporary or short-time disability resulting, in the main, from acute illness, and causing a temporary interruption of earnings. At the other extreme, there is permanent total disability resulting from chronic disease or from injuries causing loss of limb, sight, etc. In such cases the disabled person will be incapacitated for the remainder of his life and will require support until death. Between these extremes there is a third type consisting of cases of disability which are neither temporary, in the sense of lasting but a short time, nor permanent, in that disability will endure until death. These are cases of long-continued illness which persist for a long period before they terminate in recovery or are judged to be permanent in nature. Many cases of this type can be separated from either temporary or permanent disability only by arbitrary criteria. For example, in many cases of chronic disease physicians will be reluctant to render a definite judgment whether the patient will or will not be permanently disabled.

Many characteristics of long-continued illness are similar to those of permanent disability. Administrative and financial problems in providing insurance protection are also similar. It is, therefore, logical to draw these two types together. This is generally the practice in foreign social insurance systems; long-continued or chronic illnesses and permanent disability, taken together, are known as invalidity.

A single system of disability insurance could be established to compensate both temporary disability and invalidity. Such a procedure would have some obvious and important advantages. It would permit easy coordination or integration of the disability insurance system with any system or systems for the provision of medical care; and it would avoid the necessity of making a more or less arbitrary distinction between types of disability which shade imperceptibly into each other. With a single system, gaps in a disability insurance program could be more easily avoided than if there were two separate systems. Medical examination of claimants is necessary in both temporary disability and invalidity, in order to ascertain whether disability exists, and the utilization of common facilities for this purpose would have obvious advantages.

There are also important considerations which argue for differentiation of temporary disability from invalidity and for setting up separate, though coordinated, insurance systems to deal with each type. There are substantial reasons why the benefit rate should be less for invalidity than in temporary disability cases. The criteria in judging and certifying the presence of disability in the two cases should differ in important respects. The concentration of invalidity cases in the older ages argues for a smooth coordination of invalidity and old-age benefits, though such a relationship with old age is much less important for temporary disability. The finances of the two types of insurance have important differences; temporary disability occurs relatively frequently but the benefits are relatively inexpensive in the individual case,

and the reverse is true for invalidity; furthermore, maturity is reached quickly in temporary disability insurance, but only after the lapse of 15 or more years in permanent disability insurance. The relatively high cost of benefits in individual invalidity cases justifies stricter eligibility conditions in an insurance system of limited coverage than would be necessary for temporary disability. The need for repetitive certification of temporary disabilities, as against infrequent recertification of invalidity, implies some fundamental differences in the administration mechanism.

These and other differences in the problems of insuring against temporary disability and invalidity must be given careful consideration, but they must not be permitted to obscure the important points of similarity between the two.

There is only one foreign system of social insurance, the British, which treats all disability as a continuing risk, no matter how long the disability lasts. But even the British system makes certain distinctions between temporary as against long-continued and permanent disability. The rate of benefits is reduced one half after disability has lasted six months, and the criterion of disability is changed as soon as it becomes apparent that an individual will be unable to engage in his former line of work. All other foreign social insurance systems have linked invalidity insurance with old-age insurance (many of these systems calculate the pensions payable in invalidity and old age by the same basic formula) and generally they have linked temporary disability with medical care insurance, the combined system being known as health or sickness insurance.

In foreign systems, the distinction between temporary disability and invalidity is made in various ways. In Great Britain the line is drawn on a time basis, that is, the worker is entitled to draw temporary disability ("sickness") benefits for a maximum of 26 weeks in a year; if disability still persists he goes on invalidity ("disablement") benefit at half the rate of the sickness benefit. In Germany the sickness insurance system is responsible for paying benefits during the first six months of disability in illnesses which are not considered likely to result in permanent disability. In cases which are judged to be permanent the invalidity insurance system pays the benefits from the outset or as soon as a prognosis of permanency is made; this system also pays the benefits in all cases of disability lasting beyond six months. In France the sickness insurance system pays benefits during the first six months of any illness; at the expiration of this period the invalidity insurance system becomes responsible. The same procedure was followed in Czechoslovakia, except that the line of demarcation was drawn at the expiration of a year's period.

If the distinction between temporary disability and invalidity is made according to the criterion of duration only, the line must be drawn at some arbitrary point. There is nothing in the frequency curve for illnesses of different durations which would indicate that the dividing line should be drawn at 26 weeks, 39 weeks, a year, or at any subsequent point. The distinction between temporary disability and invalidity may be drawn at whatever point is desirable in the light of economic and social considerations.

Foreign experience suggests that, if it is found desirable to make a distinction in the United States between temporary disability and invalidity, the line of demarcation may be drawn in one of several ways. We could follow the pattern of the British health insurance system and, avoiding the problems involved in the certification of permanency of disability, draw the line at, say, 13 weeks, 26 weeks, 39 weeks or one year. Or we might follow the German example, namely, to draw the line at six months' duration but to classify all cases of permanent disability as invalidity sooner if a prognosis of permanent disability is made before the expiration of six months. Still a third approach might be to distinguish the cases which are clearly permanent disability and to classify all other cases as temporary disability; if the temporary disability benefits are more generous in such a plan than those given in the cases judged to be permanent, it would probably be desirable or necessary to reduce the amount or the rate of temporary disability benefits after such benefits have been paid for a specified number of weeks.

Drawing the line of demarcation solely on a time basis has the following advantages: (1) It eliminates the problem of deciding, in specific cases, whether or not disability is likely to be permanent; (2) it allows the disabled person to know definitely what benefit he may expect—the amount of his benefit will not hinge upon a physician's prophecy of permanent or temporary disability; (3) during the period for temporary disability benefits, it assures both the permanently disabled person and the person suffering from illness which may or may not result in permanent incapacity of receiving the same amount of benefits. This permits the permanently disabled person to make a gradual adjustment in his standard of living. In foreign countries which place permanent disability under the jurisdiction of invalidity insurance as soon as a prognosis of permanency is made, there is often a jurisdictional problem between the sickness insurance and the invalidity insurance institutions, each having an interest in avoiding the payment of benefits in cases which they consider should be the responsibility of the other.

The question of how to draw the line of demarcation between temporary disability and invalidity will be influenced very greatly in the United States by the administrative problems involved in coordinating or integrating the social insurance programs. This question is complicated by the fact that old-age insurance is now administered by the federal government, and unemployment and workmen's compensation by the states, while the administrative level for health insurance has not yet been decided.

From what has already been said it is evident that a number of different administrative linkages are possible. Thus, insurance against invalidity might be integrated with the federal old-age and survivors insurance, and temporary disability insurance might then be linked with (a) medical-care insurance, (b) unemployment compensation, or (c) workmen's compensation, all on a state level. Or insurance against invalidity and temporary disability could be instituted through a single system, which might be either federal or state. A federal system could be integrated into or co-

ordinated with old-age and survivors insurance and with federal medical-care insurance; a state system could be linked with medical-care insurance, workmen's compensation, or with unemployment compensation, all on a state level. Other combinations are conceivable. In any case, some close relationship should exist between disability insurance and medical-care insurance. Both are concerned with the prevention of illness and disability. It is probably inevitable and desirable that the physician who treats the sick and disabled worker should render a contributory opinion as to whether the worker is disabled and when he is able to return to work. The issues involved in these questions of administrative coordination or integration of the various social insurance programs are complex and among the most important involved in designing a program of disability insurance.

## FORMULATION OF SPECIFICATIONS

In formulating a system of disability insurance, various problems must be faced in determining the specifications, irrespective of whether compensation in both types of disability is made through a single unified system or through two more or less separate systems. The precise answers which may be given are, of course, influenced according to whether a single or a dual system is to be established. In discussing together the problems for both temporary disability and invalidity we do not intend in this paper to prejudice the question whether a single unified system or a dual system is to be preferred.

### *Coverage*

To what population groups should temporary disability and invalidity insurance be extended? The purpose of disability insurance is to provide protection against loss of earnings on account of inability to work because of illness or accident. Since no one is exempt from the possibility of being disabled, it would seem that disability insurance should apply to all gainful workers, the self-employed as well as the employed. Other considerations suggest that the coverage—at least of temporary disability insurance—should be restricted to employed persons. Among employees, incapacity to work is definitely tied to loss of earnings and the amount of loss sustained may be measured by the wages the employee had been receiving. Among self-employed persons, on the contrary, temporary incapacity for work does not ncessarily cause loss of income; an employee or some other member of the family may temporarily carry on the business or enterprise. Also, it may be difficult to ascertain the precise loss which self-employed persons are sustaining because of incapacity. Another obstacle to the inclusion of the self-employed is the difficulty of collecting from them contributions geared to income. These and other considerations suggest that compulsory insurance against temporary disability should be restricted—at least at the outset—to wage and salary workers. Some of the administrative difficulties in the coverage of the self-employed are avoided, though others are created, by the use of flat contributions and flat benefits.

In the case of invalidity insurance, there is greater need than in temporary disability insurance to extend coverage to all gainful workers; even the self-employed person generally loses the means of self-support when subjected to prolonged illness or permanent disability. Inclusion of the self-employed under invalidity insurance would present the same problem as confronts the inclusion of this group under old-age insurance, namely, the difficulty of collecting contributions and, if benefits are to be geared to prior earnings, of obtaining accurate reporting of earnings. These difficulties may not be insurmountable, and the whole question requires careful study.

*Definition of Compensable Disability*

Different definitions of compensable disability and different criteria for judging whether disability exists are necessary in temporary disability and in invalidity insurance. Short-time or temporary disabilities are, in the main, due to acute illness. In such illnesses the question whether the afflicted person is or is not able to work is almost entirely a medical question; a physician must decide whether the person is too sick to work, or whether it would be prejudicial to his health or recovery to attempt to work. In most cases these questions do not present great difficulties. On the other hand, illnesses or conditions which fall within the province of invalidity insurance are, in the main, due to chronic diseases or are the result of accident or injury resulting in permanent dismemberment or loss of function. Here the condition, unlike that in acute illness, tends to remain unchanged or to change slowly. While in some instances the afflicted person will be totally disabled, in many instances there remains some capacity to perform work. The question here is whether the handicapping condition is so serious, the degree of disability so great, that the afflicted person is, by reason of his disability, incapable of substantial gainful work. A useful and practical definition must not be too strict; total disability in the sense of 100% loss of earning capacity would exclude most permanently disabled persons who cannot earn enough for their own support and the support of those who are dependent upon them.

In short-time illnesses the sick person may be totally or only partially disabled. However, even in the cases of partial disability it would seem unreasonable to judge incapacity by any other test than incapacity to engage in the usual or previous occupation. Thus, in the case of a carpenter who injures his right hand but who will recover full use of this member in a few weeks, it would seem manifestly unfair to deny him insurance benefits because he might possibly be able to work at something which does not require the use of the right hand. However, when a diseased or handicapping condition is permanent or long-continued, the insurance system is justified in asking whether there is any occupation other than the former or usual occupation in which the afflicted person might engage, and on this basis to decide whether the invalidity benefit should be paid. In such cases there ought to be a shift, in the basis of judging incapacity, from "occupational" incapacity to "general" incapacity. This shift may be made after disability has persisted for a certain fixed period, or it may be made whenever, in the opinion of physicians and the insurance

authorities, it becomes apparent or reasonably certain that the afflicted person will never again be able to resume his former occupation. The latter procedure is supposed to be the rule in Great Britain under its unified disability insurance system, but in practice the shift is often not made until the rate of benefits is reduced after 26 weeks of disability. In other countries, where temporary disability and invalidity insurance are separate, the transition is made when the disabled person passes from the one system to the other. In most foreign systems of invalidity insurance, the test of incapacity is whether an individual has lost two thirds of his earning capacity as compared with the earning capacity of individuals of similar training and experience in the same locality; in the German system for salaried workers, the test is loss of 50% of earning capacity.

In short-time illness, there is generally no question of fitting or retraining the individual for some other occupation. An important interest of invalidity insurance, however, is to ascertain whether, by appropriate training and rehabilitation measures, disabled persons may be made capable of self-support and in requiring such measures to be taken.

*Rate of Benefits*

Considerations of broad objectives, economy, and the prevention of malingering dictate that, in general, the amount or rate of benefit in temporary disability should be greater than in invalidity. However, in neither case should the benefit be less than the minimum required for subsistence.

The purpose of the benefit in temporary disability should be to tide the worker over a temporary interruption in earnings with as little alteration of his usual standard of living as possible. Benefits should therefore be a substantial portion of the ordinary earnings of the disabled person. However, full compensation would not be either economically or psychologically advisable; the benefit should be less than the disabled person's earnings. Since temporarily disabled and temporarily unemployed individuals suffer the same wage loss, and since the needs of both groups of workers are approximately the same (except for the question of medical and other sickness costs), there are many obvious advantages in favor of similar benefits for temporary disability and unemployment.

Under most of the state unemployment compensation laws, benefits are paid according to formulas which aim to yield approximately 50% of the average earnings, with a minimum frequently of $5 to $7 weekly (or three fourths of wages, whichever is less) and a maximum which in most cases is $15 a week. This scale might be adopted for temporary disability so long as it is retained in unemployment compensation. In both temporary disability and unemployment insurance, certain considerations urge an increase in the amount or rate of benefits if the unemployed or disabled person has dependents. The argument for larger disability than unemployment benefits hinges on the disabled worker's special need for medical care, special diet, or attendance.

In invalidity insurance, the rate of benefits, as we have said, ought to be less than in temporary disability. The fact that in many instances the recipient of invalidity benefit will receive this benefit until he dies or becomes eligible for an old-age pension, and that a considerable proportion of these recipients will be in the older age groups, suggests the desirability of calculating invalidity benefits by the same formula as is used for old-age benefits. Under the present federal old-age and survivors insurance system, the monthly old-age benefit for which a retired worker may qualify after age 65 is (subject to specified maximums and minimums) equal to 40% of the first $50 of average monthly earnings throughout his insured working lifetime, plus 10% of the next $200 of such earnings, increased by 1% for each year of covered employment. These benefits are supplemented if the person has a dependent wife over 65 and/or dependent children. Use of this formula for compensating invalidity under a joint old-age, survivors, and invalidity insurance system has much to be said in its favor. Such an arrangement would deal more favorably with the employee who, after a lifetime of work, became an invalid than with the younger worker. The coordination with temporary disability benefits would require some special adjustments to assure that the invalidity benefit would not be higher than the temporary disability benefit.

*Waiting Period*

In the compensation of disability, a waiting period between the onset of disability and the commencement of benefits is desirable. In the first place, a considerable proportion of all workers lose one, two, or a few days of work each year on account of illness. These losses are so small that the workers can bear them. Moreover, to pay benefits from the first day of disabling sickness would hold out undue inducement to take advantage of the provision. In addition, the compensation of wage loss from illnesses lasting but a few days would very greatly increase the administrative load and would increase the insurance costs beyond the value of the social advantages thereby attained. For example, an analysis of the disability experience of the employees of the Boston Edison Company (which has disability insurance benefits payable from the first day and at the rate of 100% of wages) over the period 1933-1937, inclusive, shows that one-day absences attributed to sickness constitute 23% of the total number of disabling cases, but account for only 3% of the total volume of sickness of less than 372 days' duration. Sicknesses lasting seven days or less constitute 83% of the cases of illness and only 33% of the volume of all sickness up to 372 days' duration.[24] It is apparent, therefore, that administrative problems will be greatly reduced and simplified if illnesses of short duration are excluded from compensation.

Many of the factors which need to be taken into account in fixing a waiting period

[24] Gafafer and Frasier, *Frequency and Duration of Disabilities Causing Absence from Work Among the Employees of a Public Utility, 1933-1937* (1938) 53 PUBLIC HEALTH REPORTS, No. 30, pp. 1273-1288. The Boston Edison Co. inaugurated its disability compensation plan in 1913. It compensates, totally or partially, loss of wages for disability beginning with the first day. During the second 6 months of membership, an employee is allowed to accumulate sick leave of 1 day per month at full pay. After the first year of membership, full pay for continuous disability is allowed for 15 weeks; beyond this time compensation is reduced to from three fourths to one fourth of the employee's wages depending upon the number of years of employment with the company.

are the same in temporary disability compensation as in unemployment compensation, although other factors are different (for instance, the different incidence of short-time illnesses as compared with short periods of unemployment). At present, the waiting period for unemployment compensation in most states is two or three weeks (cumulative). So long a waiting period is not altogether necessary for temporary disability insurance. Nevertheless, there is much to be said for having waiting periods of the same duration for both programs. In any case, the waiting period for temporary disability must be a period of continuous disability if it is to eliminate the administrative problems of dealing with brief disabilities.

The considerations governing the length of the waiting period for invalidity vary in accordance with whether there is to be a unified or a dual system of disability insurance. If there is a unified system, and the coverage for temporary disability and invalidity benefits is the same, then the waiting period for invalidity benefits could quite properly be the maximum benefit period for temporary disability benefit (except if it is intended that cases found—or declared by statute—to be unquestionably permanent are at once to be made eligible, without waiting period, for invalidity benefit). In other words, when a worker has exhausted his temporary disability benefits, he would, if he meets the stricter criteria of invalidity, automatically transfer to invalidity benefits, presumably at a lower rate. Even if the two systems are not unified they certainly should be coordinated so that invalidity insurance takes on where temporary disability insurance leaves off; there would thus be no gaps between the systems for workers who meet the qualifications for benefits under both systems. If invalidity insurance, by inclusion of self-employed persons, has a wider coverage than temporary disability, then the question of a waiting period for invalidity benefits for workers not entitled to temporary disability benefits needs to be faced on its merits. Otherwise, the question of a desirable waiting period for invalidity benefits is mainly a question of the relationship or coordination of the two systems or the two types of benefits.

*Benefit Period*

This presents no problem in invalidity insurance; invalidity benefits should be payable until the person recovers, dies, or qualifies for an old-age benefit. As regards temporary disability insurance, the question of the desirable length of benefit period (*i.e.*, the maximum number of weeks for which benefits would be paid in any one illness or in any single calendar period) is again mainly a question of the desirable relationships between the two insurance systems or between the two types of benefits.

It is important to observe that the financial problems of benefit duration for temporary disability are different from those of unemployment compensation. In the latter, the extension of the benefit period will, in times of severe unemployment, involve a very sharp and perhaps an indeterminate increase in costs; in temporary disability this is not the case. Estimates of the volume of disability under the British National Health Insurance indicate that an extension of the benefit period from 13 to 26 weeks, with a 7-day waiting period, would increase the costs by 25%. An extension

of the benefit period from 13 to 52 weeks would increase the costs by 48%. Estimates based on German workmen's insurance experience show that an extension of the benefit period from 13 to 26 weeks would increase the costs by 13%, and an extension from 13 to 52 weeks would increase the costs by 23%.[25]

*Eligibility Requirements*

Eligibility requirements are necessary in disability insurance in order to guard the insurance system against adverse selection of risks, and to avoid payment of benefits to individuals who have not had such employment histories as ensure that they are ordinarily gainfully employed or dependent upon their earnings. Under a unified system of disability insurance there would be an advantage in having the eligibility requirements for temporary disability and invalidity benefits the same so that there would be no gaps in the program. On the other hand, because of the greater potential amount of invalidity benefits, as compared with the temporary disability benefit that an individual might draw, there is much to be said for more strict eligibility requirements for invalidity than for temporary disability benefits.

## THE COSTS OF DISABILITY INSURANCE

The cost of a program of disability insurance may be best approached by considering separately the cost of insurance against temporary disability and against invalidity. In both cases, however, to obtain a precise estimate of the costs involved, it is necessary first of all to define explicitly the coverage of the proposed system or systems, the type or types of disability that will be compensable, the rate of benefits, the waiting and benefit periods, etc. Aside from these factors it needs to be understood that many other factors and circumstances will affect the costs as, for instance, the methods of medical certification employed, the availability and quality of medical care, and the efficiency with which the system is operated.

*Cost of Temporary Disability Insurance*

The rate of disability to be expected under an insurance program may be estimated from domestic statistics and from the experience of foreign countries. Illustrative data are summarized below, for males in ages 16 to 64 and for varying waiting and benefit periods. The estimated volume of disability with no waiting period and a 26-week benefit period varies from 4.5 days for the National Health Survey in the United States to 13.8 for Czechoslovakia. From what has already been said it is evident that this is more a range in "compensable" disability (actual or estimated) than in true amount of disability, though socio-economic differences in the populations, differences in the methods of collecting the data, and other differences enter to account for the wide range.

It is important to observe that the experience of the Workmen's Sick and Death Benefit Fund approaches the Manchester Unity experience (English),[26] which is

[25] The differences in the estimates of the increased cost resulting from an extension of the benefit period, based on English and German sickness experiences, must be attributed largely, if not entirely, to the fact that under the German insurance system as soon as it is established that a worker is permanently disabled he is transferred from temporary disability to the invalidity insurance fund.

[26] This is the experience for a group of British Friendly Societies analyzed by Sir Alfred Watson in 1903. This experience was used later as the actuarial basis of the British National Health Insurance.

ESTIMATED ANNUAL DAYS OF COMPENSABLE DISABILITY PER INDIVIDUAL BY SPECIFIED WAITING AND BENEFIT PERIODS, DERIVED FROM VARIOUS EXPERIENCES OF SURVEYS. MALES, AGES 16-64.[1]

| Waiting period (days) | Maximum Benefit Period (Weeks) | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 13 | 26 | 39 | 52 | 13 | 26 | 39 | 52 |
| | *Workmen's Sick and Death Benefit Fund*[2] | | | | *Manchester Unity*[5] | | | |
| 0 | 5.7 | 6.7 | 7.2 | 7.5 | 6.2 | 7.5 | 8.2 | 8.7 |
| 3 | 5.0 | 5.9 | 6.4 | 6.7 | 5.6 | 6.9 | 7.6 | 8.0 |
| 7 | 4.2 | 5.1 | 5.6 | 5.9 | 4.9 | 6.2 | 6.9 | 7.3 |
| 14 | 3.3 | 4.2 | 4.7 | 5.0 | 4.0 | 5.2 | 5.8 | 6.3 |
| 21 | 2.8 | 3.6 | 4.0 | 4.3 | 3.2 | 4.4 | 5.0 | 5.4 |
| 28 | 2.3 | 3.1 | 3.6 | 3.8 | 2.7 | 3.8 | 4.4 | 4.8 |
| | *White railroad workmen*[3] | | | | *Leipzig*[6] | | | |
| 0 | 4.4 | 5.4 | 5.9 | 6.3 | 7.3 | 8.2 | 8.5 | 8.7 |
| 3 | 3.9 | 4.8 | 5.4 | 5.8 | 6.5 | 7.3 | 7.6 | 7.8 |
| 7 | 3.4 | 4.3 | 4.8 | 5.3 | 5.4 | 6.1 | 6.5 | 6.7 |
| 14 | 2.8 | 3.6 | 4.2 | 4.6 | 4.0 | 4.7 | 5.0 | 5.3 |
| 21 | 2.4 | 3.2 | 3.7 | 4.1 | 3.0 | 3.9 | 4.2 | 4.4 |
| 28 | 2.1 | 2.8 | 3.4 | 3.8 | 2.7 | 3.3 | 3.6 | 3.8 |
| | *National Health Survey*[4] | | | | *Czechoslovakia*[7] | | | |
| 0 | 4.1 | 4.5 | 4.7 | 4.8 | 12.3 | 13.8 | 14.5 | 14.9 |
| 3 | 3.4 | 3.8 | 3.9 | 4.1 | 10.5 | 11.9 | 12.6 | 13.1 |
| 7 | 2.5 | 2.9 | 3.1 | 3.2 | 8.4 | 9.7 | 10.4 | 10.9 |
| 14 | 1.8 | 2.2 | 2.4 | 2.5 | 6.0 | 7.3 | 8.0 | 8.4 |
| 21 | 1.5 | 1.8 | 2.0 | 2.1 | 4.7 | 5.9 | 6.6 | 7.0 |
| 28 | 1.2 | 1.5 | 1.7 | 1.8 | 3.9 | 5.0 | 5.7 | 6.1 |

[1]Adjusted to the age distribution for wage returns in 1937, under the federal old-age insurance system.
[2]*Workmen's Sick and Death Benefit Fund*, ILL. HEALTH INSURANCE COMM'N REPORT (1919).
[3](1938) 53 PUBLIC HEALTH REPORTS, No. 15, pp. 555-573.
[4]Unpublished data, NATIONAL HEALTH SURVEY, 1935-1936.
[5]REPORT FOR 1912-1913 ON THE ADMINISTRATION OF THE NATIONAL INSURANCE ACT, PART I (HEALTH INSURANCE) (1913) cmd. 6907, table 1, p. 593.
[6]KRANKHEITS- UND STERBLICHKEITSVERHÄLTNISSE FÜR LEIPZIG UND UMGEGEND, 1910.
[7]STATISTIKA INVALIDNIHO A STAROBNIHO POJISTENI A NEMOCNOSTI DELNIKU ZA LETA, 1931-1932, tables 74-75, pp. 162-163.

somewhat higher than the experience under the present British National Health Insurance.[27] The volume of disability is, however, appreciably greater under the Czechoslovakian and German (Leipzig) sickness insurance systems. The relative ranking of the estimated volume of temporary disability is the same for the different benefit periods with a 7-day waiting period, varying from 2.9 days in the National Health Survey to 9.7 under the Czechoslovakian insurance system for a 26-week benefit period.

An extensive study of data illustrated in the table and of other statistics has led us to believe that the volume of disability in Great Britain under the National Health Insurance may be considered the best guide as to the volume of disability that may be anticipated in this country.

On the basis of the British experience, the volume of temporary disability that may be expected among gainfully employed workers in ages 16 to 64 for persons disabled for more than 7 days but not more than 27 weeks (that is, disabilities lasting 27 weeks in all, including the 1-week waiting period) would be approximately 6.5

[27] For a 7-day waiting period and a 26-week benefit period, the recent British experience is 5.7 days, as contrasted with 5.1 days for the Workmen's Sick and Death Benefit Fund, and 4.3 days for railroad workers.

days per annum per insured worker.[28] The assumption is made that the contemplated insurance system is to cover all wage earners and salaried workers, with a 7-day waiting period, 26-week benefit period, a qualifying provision having the same degree of strictness as the eligibility requirements of the British system, and a benefit formula essentially the same as for unemployment compensation. On these bases it is estimated that the program would cost about 1% of payrolls. The average cost per person is not likely to rise appreciably in future years; in fact, with adequate medical provisions there is reason to believe that it may decrease despite the aging of the population.

*Cost of Invalidity Insurance*

In order to determine even the general magnitude of costs of invalidity, it is essential to specify precisely the nature of disability against which protection is to be provided. The volume of compensable invalidity will depend in a large measure on the definition of the degree of disability making a person eligible for invalidity insurance benefits, and also on the administrative practices for the certification of disability.

Another problem peculiar to invalidity insurance and affecting the costs is the need for adequate rehabilitation provisions for workers who would be retrained for other gainful occupations to render them self-supporting, and the problematic estimate of the effectiveness of such provisions adds to the hazards of making a cost estimate.

The determination of the general magnitude of costs in invalidity insurance presents great difficulties, and there is a wide latitude in the bases which may be used in estimating these costs, depending on the detailed specifications of the system contemplated. In invalidity insurance the initial costs are relatively small, but they increase progressively over 15 or more years with the maturing of the system. Moreover, in invalidity the effect of aging of the population is a relatively important factor which cannot be neglected, because the incidence of invalidity is much higher among older than among younger persons. Despite these uncertainties, the general magnitude of the immediate and future costs can be determined within reasonable margins of error.

For present purposes, and by way of illustration only, the assumption is made that the system would cover all, or substantially all, employed persons; that only those workers would be entitled to benefit who have lost two thirds or more of their earning capacity for any form of gainful work; that judgment of the extent of disability would be made by the insurance authorities; that the benefit period would begin after the twenty-seventh week of disability and would terminate upon death, attainment of age 65, or whenever re-examination indicated a change in the patient's condition disqualifying him for the benefit; that the benefit formula would be the same as the present formula for old-age insurance; and that there would be qualifying provisions equivalent to "fully" and "currently" insured status in the present old-age and survivors insurance system.

[28] For both sexes—not merely for males, to which the table is limited.

On these bases it is estimated that the annual cost of invalidity insurance would probably never exceed 1% of the taxable income unless the definition of compensable invalidity is liberalized and the administrative restraints are relaxed considerably beyond the specifications assumed here. Some actuarial estimates place the cost, after about 40 years, as high as 1⅓% of payroll for a system with the assumed specifications. With more rigid requirements than we have assumed, limiting compensation, for example, to those who have lost 90% or more of earning capacity for any form of gainful work, these costs would be substantially lowered—by one third or more.

*Total Costs*

In general, it may be said that a system of disability insurance protection applying to both temporary disability and invalidity insurance, with the specifications indicated, would, at least for some considerable period of years in the future, require somewhat less than 2% of the payrolls of covered individuals. To raise the necessary revenues to meet the costs for temporary disability and invalidity insurance, the costs might be shared by employers and employees, as in the present old-age and survivors insurance, with possible participation by the federal government through appropriations from general revenues. It must not be assumed, however, that the entire amount would constitute new expenditures. At present a substantial part of the relief and assistance expenditures made by federal, state, and local governments go to families which have lost their economic independence because of disabling disease. Despite these substantial expenditures, the security that is now provided is tenuous, uncertain, and haphazard in its operation. Through properly implemented temporary disability and invalidity insurance, the risks of disability could be more effectively provided against, and the protection would be free from many undesirable effects of relief.

# A STUDY OF THE FORMULAE FOR GRANTS-IN-AID IN THE WAGNER BILL

CLARENCE HEER*

The Wagner Bill, although officially entitled the "National Health Act of 1939," might more accurately be called the "Federal Aid to Health Act of 1939." Aside from the provision of small sums for research and for the administration of the Act, the Wagner Bill does not contemplate any extension of the direct health activities of the federal government. It is primarily a grant-in-aid measure, that is, a detailed set of specifications covering the conditions under which the several states may, if they so desire, receive funds from the federal government to assist them in providing specified health services and facilities under their own state-devised and state-administered plans.

To carry out the purposes of the Act during its first year of operation, the Wagner Bill authorizes the appropriation of some $98,000,000 of federal money. Of this amount $89,000,000, or over 90%, is authorized to be paid to the states in the form of grants-in-aid.[1] The amount of federal grants actually paid out, however, will depend on the ability and willingness of the states to raise, through their own taxes or otherwise, the matching funds required under the Act. As the state health programs expand, increased federal appropriations sufficient to carry out the purposes of the Act are authorized.

Assuming full cooperation on the part of the states, it is estimated that some ten years hence, when the program reaches its maximum, federal grants for various public health services, for medical services to the needy, and for the construction and maintenance of hospitals, but excluding grants for state sickness insurance claims, will reach a total of $425,000,000 per annum. This will involve the raising of an approximately equal sum by the states and localities, bringing the total maximum cost of these three phases of the Wagner Bill to $850,000,000 per annum.[2] This sum will, for the most part, represent a net addition to the $571,000,000 of federal, state

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[1] Preliminary Report of Sub-Committee of Senate Committee on Education and Labor ("Establishing a National Health Program"), SEN. REP. No. 1139, 76th Cong., 1st Sess. (1939) 31.

[2] Message from the President of the United States Transmitting the Report and Recommendations on National Health Prepared by the Interdepartmental Committee to Coordinate Health and Welfare Activities, H. R. Doc. No. 120, 76th Cong., 1st Sess. (1939).

and local funds which it is estimated are now being spent on public health services and on hospital care in the United States.[3]

The National Health Bill, which is in the nature of an amendment to the present Social Security Act, authorizes federal grants to the states for five general purposes. Title V authorizes grants for maternal and child-health services and for medical services for children, including crippled children. Title VI authorizes payments to the states for public health work and investigations. Titles V and VI are not new, having been parts of the Social Security Act since its original enactment in 1935. The Wagner Bill, however, greatly increases the federal grants authorized under these two titles and alters the formulae for distributing the grants among the several states.

The remaining three titles of the Wagner Bill are new. Title XII authorizes grants to the states for the construction and improvement of needed hospitals and for assistance over a period of three years in defraying the operating costs of such added facilities. Title XIII authorizes grants to the states for medical care, or, to quote the exact language of the Bill, "For the purpose of enabling each State, as far as practicable under the conditions in such State, especially in rural areas and among individuals suffering from severe economic distress, to extend and improve medical care (including all services and supplies necessary for the prevention, diagnosis and treatment of illness and disability) . . ." Finally, under the provisions of Title XIV, federal grants are authorized for the purpose of assisting the states in the development, maintenance, and administration of plans for temporary disability compensation.

Although the formulae for determining the amounts of federal grants to be paid to the several states under the various titles of the Wagner Bill differ as to detail, all of them, with the exception of those provided under Title XIV, are characterized by certain uniformities of principle and procedure. These uniformities, as well as some of the major differences between the various titles of the Bill, are set forth in condensed form in Table I.

The first step in the process of making a grant under any title or sub-title of the Bill is, of course, an appropriation for that purpose by the Congress. The Wagner Bill merely authorizes appropriations within certain limits for the first three years of operation of the Act. Thereafter it authorizes whatever appropriations shall be necessary to carry out the purposes of its various titles. Within the limits of these authorizations, the actual amounts appropriated for any year will be entirely dependent upon the current action of Congress.

Once an appropriation for a grant under any of the titles or sub-titles has been made, the next step provided by the Bill is the allotment or apportionment of this appropriation among the several states on the basis of criteria specified in the Bill. The Bill provides that state allotments under Title V shall be made by the Chief of the Children's Bureau. Allotments under Titles VI and XII are to be made by the Surgeon General of the Public Health Service. Allotments under Titles XIII and XIV become a responsibility of the Social Security Board.

[3] U. S. Treas. Dep't, Bulletin, Aug. 1939, p. 4.

TABLE 1. ANALYSIS OF SALIENT PROVISIONS OF NATIONAL HEALTH BILL

| Purpose | Authorized Federal Appropriation for Federal Year 1940* | Allotting and/or Administering Agency | Basis of Allotments to States | Required Disposition of Federal and State Matched Contributions | Matching Ratios (Per cent Federal Contribution to Total Cost of Plan) |
|---|---|---|---|---|---|
| Title V: | | | | | |
| Part 1: Maternal and child-health services | $ 8,000,000 | Children's Bureau | 1) No. of births; 2) No. of mothers and children in need of services; 3) Special problems of maternal and child health; 4) Financial resources. | To finance approved State plans for *extending and improving* specified services. | 33-1/3% to 66-2/3% depending on average per capita income of State. |
| Part 2: Medical services for children, including crippled children | 13,000,000 | | 1) Child population; 2) No. of children in need of services; 3) Special problems of medical care of children; 4) Financial resources. | | |
| Part 5: Administration, investigations, and demonstrations, etc. | 2,500,000 | | | | |
| Title VI: Public health work and investigations: | | | | | |
| Part 1: Payments to States | $15,000,000 | Public Health Service | 1) Population; 2) No. of individuals in need of services; 3) Special health problems; 4) Financial resources. | Same as above. | Same as above. |
| Administration, studies, demonstrations, etc. | 1,500,000 | | | | |
| Part 2: Investigations | 3,000,000 | | | | |
| Title XII: | | | | | |
| Grants for general hopitals | $ 8,000,000 | Public Health Service | 1) The needed additional hospitals; 2) The financial resources. | To finance approved State plans for constructing and improving needed hospitals. | Same as above. |
| Grants for mental and tuberculosis hospitals | † | | | | |
| Administration, etc. Public Health Service | 1,000,000 | | | | |
| Public Works Administration (etc). | † | | | | |
| Title XIII: | | | | | |
| Grants for medical care | $35,000,000 | Social Security Board | 1) Population; 2) No. of individuals in need of services; 3) Special health problems; 4) Financial resources. | To finance approved State plans for extending and improving medical care. | 16-2/3% to 50% depending on average per capita income of State. |
| Administration | 1,000,000 | | | | |
| Title XIV: | | | | | |
| Grants for temporary disability compensation | $10,000,000 | Social Security Board | No provision for State allotments. | To finance approved State plans for temporary disability compensation. | 33-1/3% |
| Administration | 250,000 | | | | |
| Total | $98,250,000 | | | | |

*SEN. REP. No. 1139, 76th Cong., 1st Sess. (1939) 31.
†A sum sufficient to carry out the purposes of (this part of) this title.

As will be seen from Table 1, the factors or criteria to be taken into consideration in allotting appropriations for grants among the states vary according to the purpose of the grant. Thus, in determining the allotments for maternal and child-health services, the Bill directs that the following factors for the respective states be taken into consideration: (1) the total number of births in the latest calendar year for which the Bureau of the Census has available statistics; (2) the number of mothers and children in need of the services; (3) the special problems of maternal and child health; and (4) the financial resources. Grants for the construction of hospitals under Title XII are apportioned among the states on the basis of only two factors: (1) the needed additional hospitals; and (2) the financial resources.

The sum allotted to any state is not necessarily the sum it will actually receive. An allotment represents merely the maximum amount which a state may receive provided it fulfills certain conditions laid down in the Bill. It is not necessary to enumerate all of these conditions. For the present purpose, it need only be pointed out that in order to receive any funds at all, a state must submit a plan or plans for extending and improving its services and facilities along lines specified in the Bill. These plans, moreover, must be approved by the designated federal administrative agency, namely, the Children's Bureau, the Public Health Service, or the Social Security Board, as the case may be.

Most important of all as determining the amount of federal funds actually received by a state is the stipulation that the state must itself contribute from its own resources certain proportions of the total cost of each of its approved plans. The amount allotted to a state for any given purpose represents the maximum federal grant it may receive for that purpose. Within this limit, however, the amount which it actually receives is wholly dependent on the sum which it is able and willing to raise through its own efforts for the purpose of financing its plan.

As regards all of the titles of the Bill except Title XIV, the proportion of the total cost of a state plan which the federal government undertakes to contribute is a variable one determined for each state by its relative financial resources. The greater the relative financial resources of a state the smaller will be the proportion of the total cost of its approved plans which the federal government will undertake to finance and the larger will be the proportion of the cost which the state will be obliged to finance through its own efforts.

Section 1101(e) of the Bill directs that "the 'financial resources' of the several states shall be measured by per capita income accruing to the inhabitants thereof as determined jointly by the Secretary of the Treasury, the Secretary of Labor, and the Chairman of the Social Security Board, between January 1 and July 1 of each year on the basis of data for the most recent three-year period for which satisfactory data are available. . . ." As regards state plans submitted under Titles V, VI and XII of the Bill, the federal government undertakes to pay from a minimum of 33⅓% to a maximum of 66⅔% of the cost of such plans, depending on the per capita income of the states concerned. As regards plans submitted under Title XIII, the ratio of

federal support ranges from 16⅔% to 50% according to each state's per capita income. The principle of variable matching of grants is not followed in Title XIV which provides federal aid for temporary disability compensation plans. Here the proportion of federal support remains fixed at 33⅓% for all states irrespective of their per capita income.

Mississippi ranks lowest among the states on a per capita income basis. The federal government will, accordingly, undertake to defray 66⅔% of the costs of all approved plans submitted by Mississippi under Titles V, VI and XII; 50% of the costs of any plan it may submit under Title XIII; and 33⅓% of the cost of its plan, if any, under Title XIV. The District of Columbia, which for the purposes of the Bill is treated as a state, ranks first on a per capita income basis. The federal government will, accordingly, defray only 33⅓% of the cost of the District's approved plans under Title V, VI and XII; only 16⅔% of the cost of its plan under Title XIII; but 33⅓% of the cost of its plan under Title XIV. The ratios of federal support for other states will range between the above two sets of extremes, the ratios for each state being determined by its rank on a per capita income scale.

To illustrate more concretely the procedure by which the amounts of federal grants to the states would be determined under the terms of the Wagner Bill, it may be worth while to follow step by step the way in which a grant to a particular state, say Indiana, for a specific purpose, say maternal and child-health services, would be calculated. The Wagner Bill authorizes a first-year appropriation of $8,000,000 for grants to the states for the extension and improvement of maternal and child health services. It will be assumed that Congress actually appropriates this amount. It will then devolve upon the Chief of the Children's Bureau to allot this $8,000,000 to the states. In determining the amount to be allotted to each state, the Bill requires that the following factors be taken into consideration: (1) the total number of births in the latest calendar year for which the Bureau of the Census has available statistics; (2) the number of mothers and children in need of the services; (3) the special problems of maternal and child health; and (4) the financial resources. The Bill does not specify how factors like "the special problems of maternal and child health" and "the financial resources" shall be given objective and quantitative expression. Neither does it specify the respective weightings which shall be given to each of the four factors prescribed. The Chief of the Children's Bureau with the approval of the Secretary of Labor is empowered to exercise her own discretion and to prescribe her own rules and regulations on questions of this kind.

For illustrative purposes only, the Children's Bureau has worked out a preliminary formula for allotting appropriations for maternal and child-health services to the states.[4] This formula is, of course, highly tentative and it would probably be improved as experience developed. According to the formula, 25% of the appropriation would be allotted to the states on the basis of the number of live births in each state.

[4] Hearings before a Subcommittee of the Senate Committee on Education and Labor on S. 1620, 76th Cong., 1st Sess. (1939) pt. 3, p. 751. (Hereinafter cited as "Hearings").

With certain exceptions which may be disregarded for the present purpose, the remainder of the appropriation (somewhat less than three-quarters) would be allotted to the states by means of a composite index based on four statistical measures weighted as follows: average income per capita, 3; infant mortality rate, 1; maternal mortality rate, 1; and sparsity of population (square miles per 1000 population in excess of the average for the most densely populated quartile state), 1.

Application of the formula which has just been described would give to the State of Indiana an allotment of $156,349 out of the total appropriation of $8,000,000. But in order to receive any money at all from the federal government, Indiana would be obliged to match each dollar of federal contribution with a certain number of cents contributed from its own resources, the required matching ratio being determined by its per capita income.

According to the estimates of the United States Department of Commerce, the average income of the inhabitants of Indiana for the three calendar years ending with 1937 was $441 per capita. Mississippi at the bottom of the income scale had an average income for the same period of $196 per capita, while the District of Columbia at the top of the scale had an average income of $1,165 per capita. Indiana's per capita income of $441 exceeds the per capita income of Mississippi by $245, which represents approximately a quarter of the $969 by which the per capita income of the District of Columbia exceeds that of Mississippi. Indiana's matching ratio, or the proportion of federal funds which it might count on to finance an approved plan of maternal and child-health services, would, therefore, be 58.3% (the maximum ratio of 66⅔% minus one quarter of 33⅓%, the latter figure being the difference between the maximum and the minimum statutory ratios).

With a matching ratio of 58.3%, Indiana would be obliged to contribute 41.7 cents out of its own funds toward every dollar spent on its child-health program. To obtain its full allotment of $156,349 the state would, accordingly, be required to raise the sum of $112,292 from state and local sources. Any reduction in the amount of state and local support would be paralleled by a corresponding reduction in the amount of the federal contribution. Thus, if Indiana were willing to put up only $50,000 of its own money toward the purposes in question, the amount of its federal grant would be reduced to $69,904 $\left(\frac{50{,}000}{.417} - 50{,}000\right)$. In this event some $86,445 of Indiana's federal allotment would remain unobligated and unpaid at the close of the fiscal year. This unused balance would be available for reallotment to all of the states for the succeeding fiscal year in addition to the amount appropriated for that year.

The Senate Committee on Education and Labor held extensive hearings on the National Health Bill during the months of April, May, June and July of this year. The published records of these hearings reveal two types of criticism. On the one hand are the criticisms of those who appear to be out of sympathy with the Bill's major purposes, or at least with the proposed method of accomplishing those purposes. On the other hand are the criticisms of those who support the Bill's objectives

and the method of federal aid which it embodies, but who raise questions concerning particular features of the Bill. The present study deals only with the latter type of criticisms and specifically with criticisms of the formulae for distributing federal grants among the several states.

The formulae for grants-in-aid under the Wagner Health Bill have been questioned on four main counts which may be summarized briefly as follows: First, it has been said that the formulae are too indefinite and leave the determination of the amounts of individual state grants too much to the discretion of the federal authorities charged with the administration of the Act.[5] Second, it has been claimed that the proposed methods of distributing federal funds will operate to penalize progressive states which have already gone beyond the average in providing health and hospital services through their own unaided efforts.[6] Third, it has been intimated that the proposed methods of allocating grants among the states do not give sufficient weight to the needs of the several states for health and hospital services relative to their respective abilities to support such services from their own resources.[7] Fourth, differences between the formulae to be used in distributing specific types of aid have raised questions whether the various formulae are properly correlated with reference to their combined effect in promoting a comprehensive and balanced social welfare program.[8] Each of these points will be considered in turn.

That the formulae for determining allotments to states under the various titles of the National Health Act lack definiteness and leave much to administrative discretion is evident from Table 1. In determining the amounts of allotments the responsible federal officials are directed to take certain factors into consideration. They are not limited to these factors, however, nor does the Act contain any specifications as to how much weight each factor is to be accorded. Some of the factors specified such as "population," "child population," and "number of births" are definite statistical concepts which are matters of current record. Other factors such as "number of mothers and children in need of services," "special health problems" and "financial resources" have no recognized statistical counterparts. At present, at least, the selection of quantitative measures of such factors must involve personal judgments which may change from time to time.

The discretionary formulae of the National Health Bill contrast sharply with the strictly objective formulae used in apportioning federal highway aid. Under the Rural Post Roads Act of 1916, allotments to the states for highway construction are automatically determined on the basis of population, area, and mileage of rural delivery routes as certified by the Postmaster General. Similarly, the Federal Aid to Education Bill,[9] introduced by Congressman Larrabee last year, provides for the distribution of federal aid for schools by means of a definite formula which leaves no room for administrative discretion.

In defense of the discretionary bases for making allotments provided in the Wag-

[5] Hearings, 144, 448, 495.
[6] *Id.* 128-129, 144-145.
[7] *Id.* 92, 96, 159, 500.
[8] *Id.* 502, 708.
[9] H. R. 3517, 76th Cong., 1st Sess. (1939).

ner Bill, it may very well be argued that health and hospital needs are too varied and diverse to be measured by any objective formulae which will be valid for all states. If objective formulae which are merely crude approximations are tentatively used, they will undoubtedly have to be changed as experience develops and as techniques of measurement improve. But changes of this kind may be difficult to make once a particular formula has been frozen into a statute. Finally, it may be pointed out that the methods of determining state allotments under the National Health Bill are essentially the same as some of the methods now prescribed under Titles V and VI of the Social Security Act and that these methods are apparently giving satisfactory results.

In this connection, however, it must be borne in mind that the Children's Bureau, despite its discretionary powers in the matter of allotting certain funds under Title V of the present Social Security Act, has actually chosen to apportion those funds by means of objective formulae of its own devising.[10] It must also be remembered that the sums subject to discretionary allotment under the present provisions of the Social Security Act are relatively small in comparison with the sums which would have to be apportioned among the states were the National Health Bill enacted.

The chief advantage of making allotments to the states by means of objective formulae plainly written into the law is that such formulae are easier to administer and protect the administering agency against accusations of arbitrariness and discrimination. From the standpoint of the states, definite statutory formulae have the advantage of enabling each state to make its own advance calculation of the amount of federal aid it may count upon receiving, thus facilitating financial planning.

The criticism that the matching provisions of the Wagner Bill discriminate against progressive states which are already taxing themselves to the limit in order to provide health and hospital services is tied up with the question of what, according to the intent of the Act, is an approved state plan. In order to qualify for federal funds a state must first submit plans for the approval of designated federal agencies. As will be seen from Table 1, all of the titles of the Act with the exception of Title XIV specify plans for *extending and improving* health, medical and hospital services or facilities. It is plans of this particular description which the federal government agrees to finance in specified proportions, but only to the extent that the states themselves finance the remainder of the cost of such plans.

Do the above provisions of the National Health Act mean that all state and local money to be acceptable for matching purposes must be "new" money, that is, money which is additional to what the states and localities are already using and spending for health and hospital purposes? If so, the Act might conceivably lead to the type of discrimination illustrated in the following example:

State A, a progressive state, has been taxing itself heavily in order to improve its health and hospital services. In consequence, its state supported services of this nature have reached a standard considerably above the national average. State B, although

[10] Hearings, 148, 149.

possessing greater taxable resources than A, has neglected its health and hospital services, with the result that its standards are below the national average. Upon the enactment of the National Health Bill, State B submits to the appropriate federal agencies plans for extending and improving its services and facilities in order to bring them up to the level which State A is already maintaining through its own taxing efforts. From 16⅔% to 66⅔% of the cost of supporting State B's improved services will be contributed by the federal government.

State A, on the other hand, may find itself unable to raise the matching funds required further to improve its already high standard of service. In this event it will receive no aid from the federal government. Thus, State B, the wealthier state, will be assisted by the federal government to maintain the same standards of health and hospital services which the poorer State A is obliged to support entirely through its own efforts.

The possible unfairness which has just been illustrated arises, of course, from the circumstance that a state to receive any federal money at all must raise a certain proportion of matching funds through its own taxes and from the further circumstance that these state funds must apparently be used in *extending and improving* health, medical, and hospital services. In other words, state and local taxes spent in maintaining already existing services and facilities are apparently not to be counted for matching purposes. This limitation on the use of state matching funds represents a departure from the present provisions of Titles V and VI of the Social Security Act. Under the present Act, the state plans in respect of which there is a matching requirement are not "state plans for *extending and improving*" maternal and child-health services, etc., as specified in the Wagner Bill, but merely "state plans for such services." Moreover, Titles V and VI of the present Social Security Act authorize certain types of grants to the states without the requirement of matching.[10a]

One of the most serious of the criticisms voiced at the hearings respecting the grant-in-aid provisions of the Wagner Bill concerns their alleged failure to distribute federal aid among the states in accordance with the need of each state as related to its financial ability. This criticism was concisely expressed by Mrs. H. W. Ahart, President, Associated Women of the American Farm Bureau Federation, in the following language:

"The Wagner bill recognizes this need of the rural areas by specifying in each case in connection with the grants to the states that these funds are to be utilized for the purposes specified especially in rural areas and in areas suffering from severe economic distress. This recognizes where the principal need exists, but in addition we feel it would safeguard and improve the effectiveness and usefulness of this program if a more definite formula and mandate were written into the bill with respect to the apportionment of funds to the states so as to require the distribution of funds on the basis of need and the inability of the states to supply these services."[11]

Except for the reference to "rural areas" and "areas suffering from severe economic distress," there is nothing in the text of the National Health Act which expressly

[10a] Social Security Act Amendments of 1939, Pub. No. 379, 76th Cong., 1st Sess., §§502(b), 512(b), 602.

[11] Hearings, 96.

indicates a purpose to equalize health, medical and hospital services, or the state and local tax burden incident to supporting a minimum of such services throughout the United States. In this respect the National Health Bill differs markedly from the Federal Aid to Education Bill, the stated purpose of which is "to assist in equalizing educational opportunities among and within the states."

Despite any express reference to equalization in the text of the National Health Bill, it is clear from the hearings that some at least of the Bill's sponsors considered it an equalization measure. This is indicated by the following statement of Senator Wagner with reference to the Bill's grant-in-aid provisions:

> "Federal encouragement and cooperation will be effected through the traditional method of grants-in-aid allotted and distributed in a manner to bring the greatest measure of federal aid to the states which are in the greatest need of the services, and which are least able to meet those needs by their own financial resources."[12]

In another connection Senator Wagner said:

> "We are trying to help the states which, because of their lack of wealth, are not able to give as much aid, medical aid, as the wealthier states. Their aid is higher than the wealthier states; the apportionment is from one-third to two-thirds, depending upon the per capita income."[13]

Will the formulae for grants-in-aid under the National Health Bill distribute federal funds among the states on the equalizing principle? An equalizing formula must not only operate to level up interstate inequalities in standards of health and hospital services, but it must at the same time exert an influence in the direction of leveling down interstate inequalities in the state and local tax burdens incident to financing such services.

For illustrative purposes at the hearings, the Children's Bureau prepared a sample tabulation showing how a hypothetical federal appropriation of $8,000,000 for maternal and child-health services would be allotted to the states in accordance with the Bureau's interpretation of the terms of Title V of the Wagner Bill. It will be recalled that allotments to states are determined on the basis of factors which reflect each state's relative need for the services.

The tabulation also showed the respective ratios in which each state would be required to match its federal funds. These ratios range from a lower limit of 33⅓% to an upper limit of 66⅔% and depend on each state's average income per capita, which may be taken as a measure of financial ability. On the basis of the above data, reflecting both need and financial ability, the Bureau calculated the amount of matching funds which each state would have to raise from its own resources in order actually to receive its full federal allotment.

By expressing each state's quota of matching funds as a ratio of the total income received by the inhabitants of the state, it is possible to secure an approximate idea of the relative weight of the new taxes which each state would have to impose in order to secure the share of federal funds corresponding to its need. These ratios of

[12] *Id.* 111. [13] *Id.* 129.

required additional state and local taxes to total private income are given in Table 2 of the present study.

TABLE 2. REQUIRED RATES OF STATE AND LOCAL TAXATION TO ENABLE EACH STATE TO SECURE ITS FULL ALLOTMENT OF FEDERAL FUNDS UNDER AN EIGHT MILLION DOLLAR FEDERAL APPROPRIATION FOR GRANTS TO THE STATES FOR MATERNAL AND CHILD HEALTH SERVICES

| State | Total income received by inhabitants, 1937* (In millions) | Amount of matching funds required to receive full allotment from Federal Government† | Tax rate (in cents per $1,000 of income) required to raise matching funds | State | Total income received by inhabitants, 1937* (In millions) | Amount of matching funds required to receive full allotment from Federal Government† | Tax rate (in cents per $1,000 of income) required to raise matching funds |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 |
| Alabama | 671 | 159,951 | 24 | Nebraska | 578 | 55,156 | 10 |
| Arizona | 238 | 41,087 | 17 | Nevada | 92 | 27,593 | 30 |
| Arkansas | 435 | 95,178 | 22 | New Hampshire | 257 | 27,571 | 11 |
| California | 5,153 | 253,192 | 5 | New Jersey | 2,706 | 109,074 | 4 |
| Colorado | 608 | 58,277 | 10 | New Mexico | 176 | 47,570 | 27 |
| Connecticut | 1,335 | 47,648 | 4 | New York | 11,138 | 429,231 | 4 |
| Delaware | 241 | 31,243 | 13 | North Carolina | 997 | 190,891 | 19 |
| Dist. of Columbia | 789 | 58,904 | 7 | North Dakota | 223 | 37,789 | 17 |
| Florida | 806 | 78,325 | 10 | Ohio | 4,206 | 223,076 | 5 |
| Georgia | 887 | 163,026 | 18 | Oklahoma | 824 | 102,629 | 12 |
| Idaho | 240 | 34,869 | 15 | Oregon | 586 | 45,321 | 8 |
| Illinois | 5,063 | 233,186 | 5 | Pennsylvania | 5,899 | 330,408 | 6 |
| Indiana | 1,715 | 112,292 | 7 | Rhode Island | 471 | 32,067 | 16 |
| Iowa | 1,090 | 95,431 | 9 | South Carolina | 490 | 107,646 | 22 |
| Kansas | 810 | 72,711 | 9 | South Dakota | 217 | 36,449 | 17 |
| Kentucky | 860 | 129,238 | 15 | Tennessee | 862 | 124,042 | 14 |
| Louisiana | 783 | 115,850 | 15 | Texas | 2,538 | 307,262 | 12 |
| Maine | 423 | 43,910 | 10 | Utah | 251 | 38,651 | 15 |
| Maryland | 1,092 | 59,735 | 5 | Vermont | 171 | 24,927 | 15 |
| Massachusetts | 2,955 | 129,354 | 4 | Virginia | 968 | 120,782 | 12 |
| Michigan | 3,259 | 189,481 | 6 | Washington | 1,018 | 62,892 | 6 |
| Minnesota | 1,382 | 113,061 | 8 | West Virginia | 762 | 91,210 | 12 |
| Mississippi | 419 | 140,476 | 34 | Wisconsin | 1,652 | 117,537 | 7 |
| Missouri | 1,839 | 131,648 | 7 | Wyoming | 145 | 26,407 | 18 |
| Montana | 318 | 37,904 | 12 | | | | |

*U. S. DEP'T OF COMMERCE, STATE INCOME PAYMENTS, 1929-37, p. 2.
†Hearings, 755, col. (10).

It will be seen from the table that the state and local matching funds necessary to assure each state the amount of federal aid commensurate with its need will impose very unequal tax burdens on the various states. At the one extreme are the non-industrial states which would have to tax themselves with relative severity in order to secure their full allotment of federal funds. Thus, if the state matching funds were raised through a flat-rate exemptionless income tax, Mississippi would find it necessary to levy a tax of 34 cents per $1,000 of income in order to raise its matching quota. Alabama would have to levy a tax of 24 cents per $1,000; South Dakota, a tax of 22 cents; Idaho, a tax of 15 cents; and Montana, a tax of 12 cents per $1,000 of income. The industrial and commercial states, on the other hand, could raise their quotas of

matching funds and thus secure their full allotment of federal aid with a relatively mild increase in their rates of taxation. As will be seen from the table, the required rates in California, Illinois, Massachusetts, New Jersey and New York would be less than 5 cents per $1,000 of income.

It would appear from Table 2 that if federal funds for health and hospital services are actually distributed among the states according to their need for such services, the matching provisions of the bill will have the effect of exaggerating rather than of reducing existing interstate inequalities of tax burdens. This outcome may seem strange in view of the fact that the bill provides for variable matching ratios which favor the poorer states. To equalize the state and local tax burden incident to raising matching funds, however, it would be necessary to extend the present range of matching ratios beyond the maxima and minima now specified in the Bill.

It is possible that some of the poorer states would be unable or unwilling to raise their full quotas of matching funds because of the relatively heavy rates of state and local taxation involved. To the extent that this occurred, the federal aid received by the states in question would fall short of their full allotments, and the actual distribuion of federal funds among the states would not correspond to a distribution based on need. The poorer states would receive less from the federal government relative to their needs than would the wealthier states.

Despite their failure to equalize the state and local tax burden incident to raising matching funds, it should be borne in mind that the variable matching grants of the Wagner Bill go much farther in the direction of equalization than do the fixed 50-50 matching grants now specified in the Social Security Act for Old-Age Assistance, Aid to Dependent Children, and Aid to the Blind. Measured by the standards of these public assistance grants, the Wagner Bill, with its variable matching provisions, represents a distinct triumph for the principle of equalization. On the other hand, Titles V and VI of the present Social Security Act authorize the distribution of certain funds to the states for maternal and child-health services, services to crippled children, and public health work solely on the basis of relative need and financial ability and with no requirement of state matching. These latter types of grants are more effective for equalizing purposes than any matching grant, even of the variable kind. The non-matching grants of the present Social Security Act are, however, not continued in the Wagner Bill.

A final question raised at the hearings concerning the grant-in-aid formulae of the Wagner Bill was whether these formulae were properly correlated with reference to their combined effects on the promotion of a balanced, well-coordinated health, medical care and hospital program. The feature of the Bill which gives point to this question is the lack of uniformity in the matching ratios specified under its several titles.

It is apparent from Table 1 that the states with the lowest per capita income will receive $2 from the federal government for every $1 of their own funds which they spend in child-health services, public health work or hospital construction. On the

other hand, these states will receive only $1 of federal funds for every dollar of their own which they spend on medical care.

As between hospital construction and medical care, a state will obviously receive more for its money by investing in new hospitals than by spending money on the care of patients in existing institutions. But hospitals and medical care are to a large extent mutually complementary. Moreover, the relative need for the one as compared to the need for the other will vary from place to place. The arbitrary weighting in favor of hospital construction might, therefore, prove inimical to the economic budgeting of public funds.

Federal grants-in-aid are, of course, not limited to the field of health and medical care. The Social Security Act provides for grants to the states on a 50-50 matching basis for old-age assistance, aid to dependent children and aid to the blind. A Federal Aid to Education Bill providing for grants to the states on a non-matching basis was introduced at the last regular session of Congress. In view of the possible influence which the formulae under which these grants are made might exert on state and local budgetary policies, it would appear desirable to correlate all of them as far as possible in the interest of a rational allocation of public funds.

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